Integration and Coordination of Services at Migrant Health Centers

FINAL REPORT

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MIGRANT HEALTH

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Contents

Acknowledgments vi

I. Overview and Executive Summary 1

II. Analysis

Study Findings 11

Why Coordination of Services was Selected for Study 11

An Historial Perspective 13

Assessing the Impact and Value of Coordination 14

Study Purpose 16

Study Overview 17

Findings 17

Literature Review 17

Survey of All Migrant Health Centers 18

Case Studies of Integration and Coordination of Services in Selected Migrant Health Centers 18

summary 19

Coalition Development and Use of Coordinating Councils . . 19

Other Organizations Involved in Coordinated Service Arrangements 22

Barriers to Coordination and Integration of Services 23

Factors Associated with Success 24

Financial Considerations 24

Impacts and Benefits of Coordination of Services 26

Conclusions 27

Recommendations 31

Recommendations for Migrant Health Center Staff and Boards 31

Recommendations for Federal Officials 31

Recommendations for Other Organizations Serving Migrant and Seasonal Farmworkers 32

III. Case Study Reports 33

Collier Health Services 33

El Progreso del Desierto 43

Illinois Migrant council 53

Keystone Migrant Health 69

La Clínica del Cariño 75

Migrant and Rural Community Health Association 85

Plan de Salud del Valle 93

Tri-County Community Health Center 109

Yakima Valley Farmworkers Clinic 131

IV. Annotated Bibliography 143

V. Appendices

1. Matrices 1-1
Migrant Health Center Candidates for Case Study 1-2
Integration and Coordination of Services at Migrant Health Centers as of March 1990 1-4

2. Site Profiles 2-1
Collier Health Services 2-2
El Progreso del Desierto 2-3
Illinois Migrant Health 2-4
Keystone Migrant Health 2-5
La Clínica del Cariño 2-6
Migrant and Rural Community Health Association 2-7
Plan de Salud del Valle 2-8

'IX-County Community Health Center 2-9
Yakima Valley Farmworkers Clinic 2-10

3. Self-Reported Integration and Coordination of Services at Migrant Health Centers 3-1
Integration/Coordination of Category 1 Services 3-2
Integration/Coordination of Category 2 Services 3-8

4. Conventional and Coordinated Health Care Delivery Models 4-1
Comparison of Conventional and Coordinated/Integrated Health Care Delivery Models 4-2
Integrated Migrant Health Center Service Delivery Model 4-3

5. Project Work Plan 5-1

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In addition to the authors of this report, the project team included . . . ,??? provided valuable insights and thoughtful review of the project plan, protocols, and reports.

We hope the resulting report provides a useful tool for other migrant health centers seeking to develop collaborative and/or integrated services.


OVERVIEW

Integration and Coordination of Services at Migrant Health Centers

Executive Summary

Introduction

In 1991 the National Migrant Resource Program was awarded funding from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), to evaluate the extent of integration and coordination of services among migrant health centers and other organizations at the federal, state, and local levels. The resulting analysis provides case studies to help health centers and other programs to address and overcome barriers to effective coordination. The project examined the coordination experiences of exemplary health centers, then identified the success factors for potential replication,

Background

Extensive literature indicates that coordination among health and human service organizations is often critical to both the effectiveness of services and the efficient delivery of a comprehensive package of services. This is true because a high proportion of the clients of human service agencies have multiple problems and service needs, and addressing one problem while ignoring others may be ineffective. For some clients, simply telling the client where he or she can obtain another needed service may not be enough.

When delivering services to migrant farmworkers, coordination is even more crucial. Their mobility, relative disenfranchisement from a traditional network of services, and the pervasive effects of poverty produce circumstances in which farmworkers and members of their families have multiple service needs, encounter major obstacles to follow through on referrals, and are truly among the hardest to reach of all underserved populations. Language barriers, geographic isolation, and cultural and racial differences further alienate farmworkers from utilization of programs designed for local indigent populations. Moreover, migrant farmworkers generally work or reside in areas for which the health and social service resources are marginal or inadequate for meeting the needs of the year-round population.

Assessing the Value of Coordination

The migrant-specific programs mentioned above have been beneficial in that they have had a positive impact upon the lives of farmworker families, providing health care, education, job training, emergency assistance, etc. The impact upon the lives of

farmworkers can be best measured in terms of the benefits to individual families. Regretfully, measurement of the impact upon the farmworker population is virtually impossible because of the highly mobile pattern of their lives, with respect to both geography and type of employment, coupled with the constant turnover within the population as a whole. It is important to establish measurable process objectives which can be evaluated, and for which it is plausible to postulate that achievement of these objectives will lead to the desired impact on health status. Efforts to achieve these objectives will be subject to budgetary constraints, and the cost-effectiveness of alternatives will be continuously compared to justify renewed funding. However, few job descriptions prepare administrators or medical directors for the role of community organizer, and federal funding requirements pay only limited attention to the direct value of coordination of services.

The long-range strategic work plan developed by the federal Migrant Health Program in 1989 placed fresh emphasis upon the development of organized coordination efforts. Various migrant health centers have encountered and identified barriers to coordination. Some migrant health centers have overcome these barriers, and much can be learned from their success stories. Documentation of examples may encourage a continuing process of improvement by all migrant health centers; the lessons they provide may be beneficial not only to migrant health centers, but also to other local agencies serving farmworkers. Examination of the barriers and benefits of coordination will also be useful to state agencies which administer programs, and for policy making at the federal level.

Methodology

The principal tasks and products of the study were as follows:

- Conduct a literature review and prepare an annotated bibliography regarding coordination and integration of health and social services.
- Conduct a mailed survey to provide self-reports from all migrant health centers regarding the array of primary care, supplemental, and other support services directly delivered by center staff, services provided through a formal agreement with another entity, and services for which only informal arrangements exist for referral of patients to another source.
- Conduct an in-depth review at nine migrant health centers, selected to represent a diverse collection of successful developments of inter-organizational coordination and/or integration of services. Document the process through which coordination was developed, how the system works, the costs, and the benefits to the health center users, the migrant health center, and the other agencies involved.
- Analyze the experiences of the case study health centers and compare these experiences with those described in the literature. Identify barriers encoun-

tered and how they were overcome, and factors which appear to be associated with successful efforts to coordinate services.

- Develop conclusions and recommendations directed to each level of the Migrant Health Program and other agencies serving migrant and seasonal farmworkers.

Findings

A series of case studies was developed through on-site assessment of integration and coordination of services at nine migrant health centers. The case studies were developed to illustrate the difficulties and benefits of differing models for coordination end, in some cases, service integration. Using existing survey information on migrant health center services collected for its annual Directory update, NMRP prepared matrices 1) of basic service delivery information for migrant health centers by region, 2) coordination and integration of services between migrant health centers and other service organizations, and 3) migrant health center services available through coordinated efforts. Using the matrices, NMRP worked with staff in the Public Health Service regional offices to compile a pool of candidate migrant health centers from which nine models were selected by the Migrant Health Program.

Protocols were designed to check off pre-site visit activities, procedures at the site itself, and post-site visit activities. These preliminary protocols were tailored to match the actual services, settings, and health centers selected for the nine case studies. The final protocols included identification of interviewees at each site, outside organizations for interview, interview guides, and a preliminary schedule for site visits. At each of the sites, between one and three programs or activities were selected for intensive study of services coordination. In addition to interviews and observation, data collection included detailed documentation of resources involved in each of the coordination activities, the sources of these resources, and a quantification of costs for each coordination activity studied.

Complete case study descriptions are included in the final report. The site visit report, recommendations, and lessons for other migrant health centers regarding coordination and integration of services from each site were also provided as a technical assistance document for migrant health center staff and governing boards at the case study site.

Summary

Coalition Development and Use of Coordinating Councils

The Migrant Health Program promotes the use of Migrant Coordinating Councils or equivalent organizations at the state and local levels as an objective for its strategic workplan. Because the various organizations which serve or employ farmworkers have

a common interest in migrant health, shared problem identification and joint planning are most likely to lead to coordinated and efficient service delivery. The literature review on coordination and integrated service delivery provides strong support for the use of formal coordinating groups and shared planning. Similarly, community coalitions can be developed around identified problems and may provide a potent political force for change, including serving as a driving force for the creation of new programs and services and the mobilization of resources to support them.

In general the staff of the case study health centers indicated that it was valuable to organize task forces or advisory groups for new services. Coalition building was a frequently-used strategy for making things happen. Interestingly enough, participation by migrant health center governing board members in these groups was minimal, although each health center stressed that it kept the board informed and sought board approval of new service or service delivery plans. The case management model which characterized many of the services examined in this study requires the development of coordination agreements that work. Staff observed that when they started to truly manage cases, they were driven to integrate their services with others in the community. The commitment to case management is a critical driving force, and one that brings the concept of community oriented primary care into focus. Active case management in a migrant health center, if it is successful, will ultimately introduce a migrant thread into all community services used by farmworkers with any degree of frequency .

Financial Considerations

In general, the case study migrant health centers were successful in obtaining a variety of small grants or contracts to assist with development or expansion of coordinated service arrangements. However, they also took substantial financial risks in many cases. Obtaining limited financing allowed the center to build an infrastructure within the organization and establish external linkages at a low cost to the health center. In several cases these developmental activities subsequently contributed to obtaining new sources of funding which now fully support the service.

Costs can be kept low through a variety of mechanisms. Several case study sites used summer student placements from the American Medical Student Association, while other health centers directly dealt with health professions, medical, and dental schools for staff augmentation.

Other health centers maximized case management reimbursement, thereby obtaining financial support for much of their continuing efforts to develop coordinated services. Other case study sites, on the other hand, were extremely cooperative with other organizations, to the point of giving too much without payment. Still other migrant health centers exploited small grants and volunteers to the ultimate in order to develop needed services without additional Section 329 funding. In general, the migrant health centers studied found ways to mobilize other agencies' and organizations' self-interest to support their own needs. Although some organizations will not pay full price for

coordinated services, they will pay a portion. This permits the health center to provide the service to more farmworkers and, through efficient delivery, reduces the actual unit cost of services.

With a few exceptions, the total dollar amount involved in each of the coordinated services is small. This speaks well for the ability of the case study sites to accomplish a lot with limited resources. The relatively small dollar value associated with some of these activities belies the fact that many of these arrangements are complex, both organizationally and financially.

Impacts and Benefits of Coordination of Services

- For Clinic Users-Migrant and seasonal farmworkers benefit most from the coordinated programs and services documented here. More convenient access and greater acceptability in the delivery of these services has generally been a major achievement of the service development. In many cases, services have been added which are not reimbursable by Medicaid or other third party payors. In some cases, the additional services have been acquired through linkage with a program which does not have a specific mandate to serve farmworkers, but which has been willing to do so within the context of a coordinated system for care which serves all segments of the community.

- For Health Centers-Health centers are able to offer services in the context of an integrated service system which also has the unique sensitivity and capacity for responding to the needs of Hispanics and other minorities on a seasonally fluctuating basis. The case-managed services at several of the study sites are also likely to produce improved outcomes, contain costs due to health prevention activities, and ease the burdens of access and compliance with treatment on farmworker clients.

- For Other Agency(ies)—State and county agencies are able to better achieve their public health, social service, and/or educational objectives by coordinating or contracting with the migrant health centers. In many cases other organizations have obtained convenient access to primary care for their farmworker clients at little or no direct cost to their organization.

For the migrant health centers, the benefits can be categorized in several areas:

- Increased visibility and credibility in the community

- Confirmation of their role as providers of unique support services (e.g., the only group offering linguistically and culturally tailored services to the target population)

- Ability to provide opportunities to all levels of health center staff to exercise leadership in the community, achieve personal satisfaction, and build something enduring

- Expansion of services to migrant and seasonal farmworker, with at least some small subsidy beyond Section 329 funds or with an offsetting noneconomic gain which enhances the efficiency of service delivery

Conclusions

To the extent that efforts to coordinate and integrate services have been undertaken to maximize the services provided to farmworkers, they have largely succeeded. These activities have also helped to legitimize the presence and role of the migrant health center in the community, an achievement with potential long-term benefits to the health centers. The scope, magnitude, and sophistication of integration and coordination of services in the 103 migrant health centers in the U.S. varies tremendously among centers, and even between sites located in different communities. The following items summarize the conclusions of this study:

- Few current federal incentives promote the development of service coordination.
- Most service coordination efforts must be initiated and nurtured by the migrant health centers or they simply will not take place.
- Commitment of additional staff end resources is required in the initial developmental phases of a new coordination effort. On-going maintenance of such an effort is required to elevate coordination to the level of true integration.
- Service coordination and integration efforts appear to increase cost efficiency, enhance productivity, decrease provider burnout, and increase patient satisfaction.
- Interagency coordination promotes provider collaboration, increases support and colleagueship, promotes the development of other strategic alliances, enhances community acceptance, and acts as a stabilizing factor for the operations of all participating organizations.
- Coordination and integration of services by migrant health centers increases community awareness, acceptance, and public support for the migrant and seasonal farmworker population. Such efforts enhance both recruitment and retention efforts for professional provider staff by increasing staffing and flexibility, health center capacity, number and type of services provided, institutional pride, community awareness of provider achievement, and opportunities for career development; providing an opportunity for strong nursing roles in community oriented health care; positively positioning the health center for more effective advocacy; offering clinical leadership opportunities for provider staff; and coalescing the health center and the community in a team effort and reducing divisiveness by implementing joint vision.

Multiple barriers exist for migrant health centers in the integration and coordination of services. Barriers can be broken down roughly into local, state and/or regional, and

federal levels. One local factor which affects the relative success of these efforts is the overall availability of community resources. Migrant health centers which begin to integrate services in frontier or scarcely populated rural areas face a very different challenge from the larger 330/329 centers located in more suburban surroundings. Other local factors which can either facilitate or present barriers to coordination include:

- Age, size, relative stability and community image of the migrant health center
- Reputation and communication/negotiation skills of the Executive Director, Medical Director and other key personnel
- Grower support
- Support and vision of the migrant health center board of directors
- Discretionary financial resources of the migrant health center which can be allocated for developmental and organizational efforts
- Adequacy and stability of the professional provider staff, particularly the physicians
- Overall commitment of the migrant health center to the concept of case-managed care.

State and regional level factors which influence the development of integration and coordination of services include:

- Balance between need and general resource levels
- Focus on and commitment to the farmworker population
- State eligibility requirements for public services such as Medicaid and Workers Compensation
- Support from and effectiveness of the state primary care association
- Overall level of interagency collaboration within the state
- State-based incentives for service integration efforts

Factors at the federal level which impede the development of integrated service arrangements center around resource and policy issues:

- Funding policies which prioritize traditional medical care over non-reimbursable efforts, creating very real disincentives for commitment of funds necessary to initiate integrated services
- Lack of funds with the flexibility to support creative demonstration efforts

- Lack of technical assistance which would allow migrant health centers to establish optimal fiscal positioning and thus to have adequate resources to focus on interagency coordination and other collaborative efforts
- Programmatic isolation among federal agencies, which does not encourage creation of linkages from the top down

Recommendations

Recommendations for Migrant Health Center Staff and Boards

- Migrant health center governing boards should view coordination of services as an intermediate goal and comprehensive integration of services as a long-term goal. They must be prepared to provide direction to help the health center meet those goals. Health center staff must be given sufficient resources and flexibility in order to successfully organize, implement, and maintain integrated efforts. It is crucial for the migrant health center's board of directors to give the Executive Director freedom to implement their direction, even if it means taking risks on behalf of the corporation in order to overcome previously described barriers. Migrant health center boards of directors could play a pivotal role in identifying opportunities, enhancing health center position and image within the community, and providing sound business advice.
- Migrant health centers should be encouraged to adopt a more business-like approach to service integration efforts. Specifically, migrant health centers should adapt private sector techniques where appropriate, develop written interagency agreements which reflect up-to-date arrangements for involved parties, and document their experiences from one year to the next.
- Migrant health centers' financial officers should monitor cost data with respect to each of their service agreements, including developmental costs, in-kind contributions of each agency involved, revenue, and savings. Clinical and administrative staff should implement systems for tracking and evaluating outcomes of coordinated services in order to provide a context for cost effectiveness assessments.

Recommendations for Federal Officials

- It is crucial that migrant health centers be given adequate incentives, flexibility, guidance, and comprehensive and on-going technical assistance. Significant rewards need to be given for those grantees who leverage additional resources through coordination and integration of community services on behalf of migrant and seasonal farmworkers.

- The Migrant Health Program must become an effective advocate for the utilization of current resources and provider time to be devoted to the creation of these linkages. Strategic alliances developed and sanctioned at the federal level will send a message and act as models for state and local initiatives. Guidance material and policies issued by the Public Health Service should contain language which supports entrepreneurial achievement. Actual implementation of such policies should reward rather than penalize health centers for entrepreneurial creativity which clearly serves the best interest of the target population.

- A comprehensive, coordinated technical assistance initiative which focuses on building successful businesses of each migrant health center should be made available as long-term support. Strategic planning for coordination of services can be assisted through the development of self-help materials and checklists. A list of candidate services can be used to identify gaps and strengths/weaknesses in coordinated services. Migrant health centers are often the only group in the community to offer culturally sensitive and relevant services, and they should be trained to take advantage of this niche in their marketing efforts.

- Technical assistance should also be made available to train migrant health center governing board members to provide more effective direction toward meeting integration goals.

- Provider productivity figures must be reviewed in light of the fact that it is imperative for migrant health centers to be allowed to use key provider staff in leadership roles to forge these alliances.

Recommendations for Other Organizations Serving Migrant and Seasonal Farmworkers

- It is important for other organizations and agencies to recognize farmworkers as an integral part of the community they serve, even if the farmworkers are only present for part of the year. Migrant Health funding (roughly $100 per user per year for 12 percent of the total population) supports the premise that the Migrant Health Program cannot be the sole source of care for farmworkers.

- In view of the fact that service fragmentation is neither cost effective nor particularly satisfactory from a patient standpoint, coordination and integration must occur.

- All organizations serving the migrant and seasonal farmworker population should recognize the need for effective advocacy on behalf of these at-risk, hard-to-reach, and challenging clients. The use of a case management approach will facilitate the development of collaborative and integrated services. Agency flexibility, good will, and colleagueship will enhance cost effectiveness and can allow each organization to more fully implement its mission.


ANALYSIS

integration and Coordination of Services at Migrant Health Centers

Study Findings

Why Coordination of Services was Selected for Study

Extensive literature indicates that coordination among health and -human service organizations is often critical to both the effectiveness of services and the efficient delivery of a comprehensive package of services. This is true because a high proportion of the clients of human service agencies have multiple problems and service needs, and addressing one problem while ignoring others may be ineffective. Examples which illustrate the point include: 1) treating an infant for an acute gastrointestinal disturbance, but not helping the indigent mother obtain access to a supplemental food program, or treating the gastrointestinal disturbance in the infant and providing the formula, but not addressing the problem of contaminated drinking water in the camp where she lives, 2) providing treatment for skin infections to a family without shelter, and 3) prescribing a medication for a patient who has no means of having the prescription filled. For some-but not all—clients, simply telling the client where he or she can obtain another needed service may not be enough, particularly if the location is miles away and the client has no transportation, the service is urgently needed but an appointment is required and there is a 10 day wait for appointments, etc.

When delivering services to migrant farmworkers, coordination is even more crucial. Their mobility, relative disenfranchisement from a traditional network of services, and the pervasive effects of a poverty-level existence produce circumstances in which farmworkers and members of their families have multiple service needs, encounter major obstacles to follow through on referrals, and are truly among the hardest to reach of all underserved populations. Language barriers, geographic isolation, and cultural and racial differences further alienate farmworkers from utilization of programs designed for local indigent populations. Moreover, migrant farmworkers generally work or reside in areas for which the health and social service resources are marginal or inadequate for meeting the needs of the year-round population.

In order to overcome these barriers, funds are available to provide services which are specially designed for migrant and seasonal farmworkers. Congress has heard the calls to help this population, and to help the local population as well as those growers who depend on farmworkers to harvest the crops. Section 329 of the Public Health Service Act'provides support so that health services can be made available in a manner which is both accessible and appropriate to the needs of the farmworker population. In the same decade in which Congress recognized the need for federal responsibility for the health status of farmworkers, other migrant-specific services were also instituted. These include programs funded through the Department of Labor (job training and

emergency assistance), the Department of Education (Migrant Education), and other Department of Health and Human Services (DHHS) agencies (Head Start, for example). Additional federally-funded programs with specific responsibility for services to farmworkers include those operated by the Legal Services Organization, the Farmers Home Administration, and the Women, Infants, and Children (WIC) program administered by the Department of Agriculture.

In instituting these services, it was the intent of Congress to recognize that general access, cultural barriers, and a seasonal influx of farmworkers could very easily overburden a rural community's human services system. It was never intended that the migrant-specific services should supplant all pre-existing community services, nor was the intent necessarily to create a separate, parallel, segregated system just for farmworkers. Rather, supplemental and sometimes completely separate funding support would be provided for meeting the special needs of farmworkers, for delivery of services in a manner acceptable and convenient to migrants, and for assisting in overcoming barriers to utilization of existing service systems by farmworkers.

Coordination of services is a means of enhancing the effectiveness of service delivery, reducing total costs of services, and enhancing the convenience and acceptability of service delivery from the patient's perspective. Coordination can occur between different service delivery organizations or even among providers within a single organization. Coordination reduces duplication of efforts, increases the convenience for the patient, and sequences services in ways which enhance their effectiveness. Through use of common assessment and care planning processes, comprehensive services can be provided to patients or clients through separate but coordinated service delivery units or through an integrated single-site delivery system. Services are often, but not necessarily, integrated through cc-location, automatic communication among providers through sharing of records, diagnostic and administrative procedures (such as use of a common intake form, scheduling of multiple services through a single appointment, etc.), and cross-trained staff.

There are gradations of coordination and integration of services. At one extreme is the concept of "one-stop shopping," in which a single organization delivers all of the health and social services needed by its clients at a single location. Services are not only consolidated at the single location, but information collection is also coordinated, duplication avoided, and the delivery of all services sequenced so as to enhance effectiveness, convenience for the patient, and delivery efficiency. Such a model is generally not practical in sparsely populated rural areas with a shortage of community resources. A variation on the one-stop shopping model is the contractual model, in which one organization takes responsibility for arranging and assuring that all of the needed services are provided in a coordinated manner. Sometimes the responsible organization may contract with other agencies for specific services, some of which may be co-located while others may require that the client travel to service delivery sites operated by other agencies. A further variation is the consortium or collaborative model, in which each agency maintains its separate identity, but all agree to facilitate cross-referrals, establish routine procedures for exchange of client information, and even share or coordinate use of support resources. Agreements among service providers

in a collaborative model generally should be formalized to prevent misunderstanding, specify expectations against which performance can be evaluated, and provide for continuity of relationships in the event of turnover among key staff,

An Historical Perspective

Migrant health centers have actually epitomized the best of all potential coordination models at various points in their history. Born out of a consortium of public health departments and local grass-roots organizations, today's migrant health centers are the result of true collaboration. It is to the credit of the public health departments that they recognized the need for another vehicle to provide care beyond that which they were equipped to offer. As a result of these beginnings, migrant health centers experienced a period in their history when provision of coordinated care was the norm, not the exception.

Past studies have documented the benefits and difficulties of achieving even modest levels of service coordination. Even within a single organization, the coordinated delivery of different but related services to clients with multiple needs requires deliberate effort. Negotiating, planning, implementing, and maintaining even modest levels of coordination across several separate service delivery organizations is often complex and subject to disruptions from a variety of external and internal sources. Co-location of services in joint delivery sites facilitates inter-organizational coordination, but there are very real obstacles to achieving true service integration.

In the 1970s, federally-funded, and some state initiated, service integration demonstrations were launched with great expectations. These demonstrations represented a major effort to resolve identified weaknesses caused by fragmented delivery systems, particularly for welfare and human services. Many of the demonstrations did not achieve their intended level of success, and from these experiences a number of lessons were distilled which apply today. Obstacles to service integration occurred at every level, beginning with the categorical nature of programs authorized by laws enacted by Congress and the bureaucracies established to administer them. Fragmentation was encouraged, if not required, by the regulations which governed many of these programs. In describing the problems observed in attempts to implement consolidated service projects, one 1975 report concluded that "in the absence of decisive DHEW initiative, services integration will remain a marginal phenomenon." However, some successes were observed, failures were attributed to poor implementation rather than faulty concepts, and efforts to overcome the obstacles continued. Further studies indicated that this continued attention was justified, and documented benefits when service consolidations were well implemented. In the early 1980s, studies were even conducted of the manner in which agencies within the Public Health Service did and did not collaborate, and of some of the resulting effects. In a landmark study, the Institute of Medicine reviewed the experience in health services integration and summarized the lessons learned and potential benefits (Institute of Medicine, 1982). By the mid-1980s, the literature on service integration was voluminous; there was

substantial progress in integrating welfare services such as AFDC, Medicaid, and food stamps, but some obstacles to achieving the expected benefits remained to be addressed (U.S. General Accounting Office, 1986).

With respect to services to migrant and seasonal farmworkers, a 1977 study identified the different definitions within and across levels of government as one of the principal barriers to be overcome. This problem continues today, although a federal Interagency Committee on Migrants has taken up the task of attempting to address and resolve these differences. An example of the problems of achieving service coordination when differing funding agencies are involved with complementary programs is described in a study of WIC/Maternal and Child Health coordination (Pindus et *al* 1986). Although the U.S. Department of Agriculture, which administers WIC, and the Public Health Service, which administers the Maternal and Child Health program, clearly saw the potential benefits and acted to coordinate their programs at the federal and state levels, very real barriers continued to frustrate some but not all projects at the local level. Achieving service coordination and the true integration of services is hard work, and although the benefits to the clients are obvious, benefits may not accrue to all those who must commit to do this hard work, depending on how collaborative agreements are structured. It is, therefore, not surprising that achievements have been spotty except when there are clearly defined benefits for the service provider organizations.

Assessing the Impact and Value of Coordination

The migrant-specific programs or program components mentioned above have been beneficial in that they have had a positive impact upon the lives of farmworker families, providing health care, education, job training, emergency assistance, etc. The impact upon the lives of farmworkers can be best measured in terms of the benefits to individual families (i.e., a health care problem which is remedied, or educational achievement within a family which exceeds the tradition for that family). Regretfully, measurement of the impact upon the farmworker population is virtually impossible because of the highly mobile pattern of their lives, with respect to both geography and type of employment, coupled with the constant turnover within the population as a whole.

The constant transition of families moving into and out of the migrant labor stream results in a continuous flow of hundreds of thousands of individuals through the eligibility *screens* of the various programs. Although some families may stay in migrant labor for years, or even generations, others may use migrant farm labor as a stepping stone to higher occupational achievement. It is not feasible to take 'snapshots in time" of the farmworker population, then to compare its status ten years later, nor could we attribute any differences solely to the intervention of migrant-specific programs. Therefore, it is important that we establish measurable process objectives which can be evaluated, and for which it is plausible to postulate that achievement of

these objectives will lead to the desired impact on health status. The process objectives relate to the implementation of a system which delivers a continuum of services which are responsive to the array of needs of farmworkers, and to the systematic identification and amelioration of barriers to timely and appropriate utilization of this system. Efforts to achieve these objectives will be subject to budgetary constraints, and the cost-effectiveness of alternatives will be continuously compared to justify renewed funding.

Few job descriptions prepare administrators or medical directors for the role of community organizer, and federal funding requirements pay only limited attention to the direct value of coordination of services. The process of review of federal grants takes interagency coordination into consideration in a small way, but the grading system is one which could result in an "A" rating even if the total operation is at odds with the community it serves. Moreover, value of coordination at the local service delivery level should not be measured and appraised in a vacuum. The degree of coordination and communication among agencies at the federal and state level plays an important role in setting the tone and the example for full cooperation at all levels. The obstacles to coordination may be greater in one community than another, and although the "value" for achieving a given level of coordination from the client perspective may be the same, it may reflect vastly differing levels of administrative talent and perseverance.

The long-range strategic work plan developed by the federal Migrant Health Program in 1989 included specification of efforts to encourage the development of Interagency Coordination Councils at the state and local levels. Such a Council exists at the federal level. This plan placed fresh emphasis upon the development of organized coordination efforts. Response from migrant health centers ranged from "we already have excellent coordination among all agencies serving migrants in our area" to Yell us how to get started," and included reports that in some communities key agencies or organizations were uncooperative or even frankly hostile to one another. Clearly, a full spectrum of degrees of coordination among migrant health centers and other agencies exists today. Various migrant health centers have encountered and identified barriers to coordination. Some migrant health centers have overcome these barriers, and much can be learned from their success stories, in terms of both the process of coordination and the benefits which result. Documentation of examples may encourage a continuing process of improvement by all migrant health centers; the lessons they provide may be beneficial not only to migrant health centers, but also to other local agencies serving farmworkers. Examination of the barriers and benefits of coordination will also be useful to state agencies which administer programs, and for policy making at the federal level.

Until coordination is recognized officially as a critical issue and sanctions and incentives are provided to stimulate their incorporation into the monitoring and funding standards of the Migrant Health Program, such coordination will occur in some but not all migrant health centers. Currently, individual programs make it happen by virtue of personal and corporate commitment, or as a result of an initiative by other organizations or coalitions. The purpose of this study is to evaluate in detail the factors

and circumstances which come into play to create "exemplary" models of interagency coordination of services. Although emphasis has been placed upon the positive, factors to be avoided have also been identified. Further, the study provides a crude evaluation of the extent of integration and coordination among all Migrant Health Program grantees in 1991, a measure which may serve as a baseline against which to compare future status and derive quantitative descriptions of change.

Study Purpose

Regretfully, it appears that coordination of services is not the norm. Rather, it occurs in some communities and projects and not in others. Moreover, once achieved, the changes may not be permanent. For example, some migrant health centers which have a reputation for traditionally providing comprehensive coordination of services may no longer do so. Thus, there are a number of reasons for undertaking a study of coordination and integration of services in migrant health centers at this time, including:

- The constraints on federal appropriations for Section 329 prevent serving all farmworkers if they would seek services in the funded migrant health centers; there is intense competition for limited dollars for expansion or improvement.
- Service coordination and integration may contribute to the cost-effectiveness of migrant health centers, thereby permitting them to accomplish more with fewer resources. However, this hypothesis needs to be carefully tested.
- The federal Interagency Committee on Migrants and the Migrant Health Program initiative to promote coordinating councils at the state and local levels may provide a mechanism for addressing barriers to coordination and integration, but only if the barriers are identified and if there are good reasons for taking action.
- Current federal program guidance may provide barriers to the implementation of long-term service integration efforts.

The present study was designed to meet the needs implicit in the above statements. Further, it provides illustrative case studies to assist migrant health center and other program staff to address and overcome the barriers to effective coordination. This report contains a review and analysis of the coordination experiences of exemplary migrant health centers, and attempts to 'package" their lessons and success factors to improve the potential for replication. In the process of selecting the sites to be studied, the experiences of all 329-funded migrant health centers were crudely measured, thus establishing a program-wide baseline and providing a database for program-specific analyses.

Through the documentation of the experiences of the case studies, the literature review, and the survey of self-reported coordination/integration of services among all

migrant health centers, conclusions have been drawn and several recommendations synthesized.

Study Overview

The principal tasks and products of the study were as follows:

- Conduct a literature review and prepare an annotated bibliography regarding coordination and integration of health and social services.
- Conduct a mailed survey to provide se&reports from all migrant health centers regarding the array of primary care, supplemental, and other support services directly delivered by center staff, services provided through a formal agreement with another entity, and services for which only informal arrangements exist for referral of patients to another source.
- Conduct an in-depth review at nine migrant health centers, selected to represent a diverse collection of successful developments of inter-organizational coordination and/or integration of services. (Appendix 1 contains the matrices used for site selection.) Document the process through which coordination was developed, how the system works, the costs, and the benefits to the health center users, the migrant health center, and the other agencies involved.
- Analyze the experiences of the case study health centers and compare these experiences with those described in the literature. The analysis focused on the process for developing coordination of services, the barriers encountered and how they were overcome, and the identification of factors which appear to be associated with successful efforts to coordinate services. (Appendix 2 contains site profiles for the nine sites studied.) The analyses were used to develop the conclusions and recommendations which appear in this report. Recommendations are directed to each level of the Migrant Health Program (to the individual migrant health center, to the Public Health Service regional offices, and to the Migrant Health Program in Rockville), and to other agencies serving migrant and seasonal farmworkers.

Findings

Literature Review

The literature review, undertaken at the beginning of the study, concentrated on literature since the 1982 study on health services integration conducted by the Institute of Medicine, National Academy of Sciences. Few references directly dealing with migrant farmworkers-and even fewer dealing with coordination of health services to farmworkers-were identified. However, a rich body of literature on needs, methods, and examples of planning and implementing coordinated programs in the

health and human services fields was discovered. An annotated bibliography was produced and is included in this report.

Survey of All Migrant Health Centers

The National Migrant Resource Program periodically surveys all migrant health centers, using the responses to publish an annual directory. As part of the present study, the directory update questionnaire was expanded and greater effort devoted to screening, review, and follow-up of the responses. The resulting data were used to improve the comprehensiveness of the 1991 *Migrant Health Centers Referral* Directory, and to provide crude quantitative measurement of the extent of coordination and service integration in the Migrant Health Program as of 1991.

In addition to being used in the publication of the 1991 Directory, this data has been compiled in Appendix 3. The full array of services provided has been broken down into two categories: Category 1 includes the mandated primary care services which migrant health centers are required to provide and Category 2 includes substance abuse treatment, mental health, housing, environmental, and other additional services. This compilation of data denotes, on a center-by-center basis, whether the given service is provide directly on-site by the grantee, is provided by another entity under formal agreement, or is referred out on an informal basis.

Case Studies of Integration and Coordination of Services in Selected Migrant Health Centers

A series of case studies was developed through on-site assessment of integration and coordination of services at nine migrant health centers. The case studies were developed to illustrate for other migrant health centers, organizations serving farmworkers and seeking linkages with sources of primary care, and state and federal officials the difficulties and benefits of differing models for coordination and, in some cases, service integration.

Using existing survey information on migrant health center services collected for its annual Directory update, NMRP prepared matrices 1) of basic service delivery information for migrant health centers by region, 2) coordination and integration of services between migrant health centers and other service organizations, and 3) migrant health center services available through coordinated efforts. This information is presented in Appendix 3. Using the matrices, NMRP worked with staff in the Public Health Service regional offices to compile a pool of candidate migrant health centers from which nine models were selected by the Migrant Health Program. The final matrix of case study sites appears in Appendix 1.

Protocols were designed to check off pre-site visit activities, procedures at the site itself, and post-site visit activities. These preliminary protocols were tailored to match the actual services, settings, and health centers selected for the nine case studies. The final protocols included identification of interviewees at each site, outside organiza-

tion, organizing coordinated services delivery, and building the infrastructure to support future initiatives. As a major provider of comprehensive services in its area, YVFC was able to directly interact with the local political structure to implement its agenda for expanding the services for Hispanics and other minorities in the area. The children's case management services operated by YVFC was coordinated with the full array of community services, including schools, juvenile justice system, and primary care. However, throughout the development of this new service by YVFC the Migrant Coordinating Council was an obstacle rather than a facilitator.

La Clínica actually integrated a number of its services with those of the Health Department and Department of Human Services. Although coordination with the health department was formal, much of the coordination by La Clínica with other agencies and organizations administering special programs for farmworkers was informal and negotiated on an individual organization basis. IMC, on the other hand, played an exemplary leadership role in the state Interagency Committee on Migrant Health. As a result, the state Department of Health and Department of Labor participates with IMC in services planning and are responsive to initiatives to better coordinate services. All county health departments, for example, coordinate with IMC in the provision of WIC, immunizations, family planning, prenatal care, screening, diagnosis and treatment of sexually transmitted diseases, and dental care, when available. Given the nominal levels of Section 329 resources available to IMC and the low density of farmworkers in the state, it was essential that a distributed delivery system be used, a system which could not be supported only through IMC. IMC also coordinates with other state departments, including Migrant Education and Head Start, the Rural Community Assistance Program, and the Department of Public Aid. For many of these other service providers, IMC did outreach and provided translation services when needed, while the various programs accommodated the special needs of IMC's clients. At most IMC sites, referral for jobs, English as a second language, adult basic education, housing assistance, emergency food, and primary care access were co-located.

MARCHA is another case study migrant health center which actively used the Migrant Coordinating Council to achieve breakthroughs in planning and delivery of services. In Michigan, the Department of Social Services fostered creation of a state level coordinating council and also promoted local coordinating councils. As a result, an environment was created in which shared planning and prioritization could flourish. These activities led MARCHA and Migrant Education to integrate pediatric primary care and school health activities in an efficient system of care.

Keystone contracted with the statewide Migrant Health grantee to provide services in two counties. Thus, it benefits from some statewide coordination without directly participating. However, Keystone is developing a variety of direct agreements with the state for various categorical programs, such as TB/HIV screening, treatment of sexually transmitted diseases, and drug abuse prevention. Within the county, Keystone staff played a leadership role in organizing coalitions to address problems such as need for low income housing for farmworkers. Keystone is working on developing an integrated service setting which would provide WIC, WIN, SCAR (Community

workplan. Because the various organizations which serve or employ farmworkers have a common interest in migrant health, shared problem identification and joint planning are most likely to lead to coordinated and efficient service delivery. The literature review on coordination and integrated service delivery provides strong support for the use of formal coordinating groups and shared planning. Similarly, community coalitions can be developed around identified problems and may provide a potent political force for change, including serving as a driving force for the creation of new programs and services and the mobilization of resources to support them. Rural areas tend to have few community resources, and those that are available must be used efficiently. Deployment of community resources will be most effective if there is a consensus as to needs and priorities for services. With community-based strategic planning, resource allocation is deliberate. In the absence of such planning, providers will be blamed (with some justification) for gaps and shortfalls.

Although five of the migrant health centers selected for case studies were active participants in Migrant Coordinating Councils or equivalent interagency groups, only four of these appeared to be effectively using the councils to identify problems, set priorities, and develop or improve coordination of service delivery. In one case there was a Migrant Coordinating Council on paper, but no evidence that it had any recent impact; another council was hostile to migrant health center efforts. All of the case study health centers had extensive relationships with other organizations and, in some cases, had assisted in the development of community coalitions around specific problems or service needs. Salud, for example, was actively involved with a local consortium organized to do something about the needs for better housing for farmworker families. The health center was encouraging the formation of a Growers Council as a mechanism to insure input from growers into the evolution Salud's environmental health program, and coordinated extensively with the state and county health department programs.

Tri-County had an active Migrant Coordinating Council in one of the three counties served, and worked with this group to advance the visibility and coordination of substance abuse interventions. Tri-County was also the only case study site which had designated one individual as a full-time coalition coordinator. 'X-County's Farmers in Prevention (FIP) program supported the coalition coordinator, and FIP itself was used as a vehicle for initiating grower involvement, coordinating with a number of health-related volunteer organizations, and participating with the public education system in prevention activities. All of this was accomplished in a community which has historically been indifferent, at best, regarding issues of substance abuse as a community problem, and which often has been antagonistic towards migrant health services. By addressing a service needed by all farmworkers and their families, 'IX-County both expanded farmworkers' access to substance abuse services and moved one step towards an integrated service system which serves all elements of the population.

El Progreso provided leadership in coalition development around the issue of prevention and services to HIV-positive individuals. The Coachella Valley AIDS Consortium, Familias y Sida, and the Coalition de Recursos provided vehicles for needs identifica-

tions for interview, interview guides, and a preliminary schedule for site visits (Appendix 5). These instruments were pilot tested at a single case study site and refined based on comments received at the pilot test before the remaining eight site visits were conducted.

At each of the sites, between one and three programs or activities were selected for intensive study of services coordination. In addition to interviews and observation, data collection included detailed documentation of resources involved in each of the coordination activities, the sources of these resources, and a quantification of costs of each coordination activity studied.

Complete case study descriptions are included in this report. Appendix 2 summarizes the services selected for documentation at each case study stie and lists the resulting advantages or benefits from the perspective of clinic users, the migrant health center, and the other agency or organization which coordinated or supported consolidation of services with the migrant health center. In addition to appearing here, the site visit report, recommendations, and lessons for other migrant health centers regarding coordination end integration of services from each site were also provided as a technical assistance document for migrant health center staff and governing boards at the case study site.

Summary

The following paragraphs summarize observations from the sits case studies concerning coalition development and use of coordinating councils, the array of organizations involved in coordinated services arrangements, barriers to coordination and integration of services, factors associated with success in coordination/integration of services, financial considerations, and impacts and benefits. A review of the case study reports in section III of this report will facilitate understanding of the discussion which follows. This report refers to the case study sites as follows:

Collier	Collier Health Services, Immokalee, FL
El Progreso	El Progreso del Desierto, Coachella, CA
IMC	Illinois Migrant council, Chicago, IL
Keystone	Keystone Migrant Health, Chambersburg, PA
La Clínica	La Clínica del Cariño, Hood River, OR
MARCHA	Migrant and Rural Community Health Association, Bangor, MI
Salud	Plan de Salud del Valle, Fort Lupton, CO
Tri-County	Tri-County Community Health Center, Newton Grove, NC
YVFC	Yakima Valley Farmworkers Clinic, Toppenish, WA

Coalition Development and Use of Coordinating Councils

The Migrant Health Program promotes the use of Migrant Coordinating Councils or equivalent organizations at the state and local levels as an objective for its strategic

Action), shelter, maternal and child health, family planning, title XX social services, and primary care under one roof. Keystone already does nutrition assessment and certification for WIC. Growers have started to invite Keystone to be represented at their meetings. In general, Keystone operates through the cooperation of existing providers and programs, convincing them of the advantages of working together to achieve mutual objectives.

Collier worked with the state, the county, the osteopathic medical school, and the community hospital in Naples to create an integrated and coordinated health service system in Immokalee. Collier also operates an insurance demonstration program, funded by the Migrant Health Program, in which migrant farmworkers receive a Blue Cross/Blue Shield card which can be used to cover limited benefits when out of the area. Most of the coordination was developed through one-on-one negotiation rather than through a council of organizations serving farmworkers. In one instance a coalition was organized to promote county support for maintenance of an urgent care center which Collier was being forced to close due to financial reasons.

In general the staff of the case study health centers indicated that it was valuable to organize task forces or advisory groups for new services. Coalition building was a frequently-used strategy for making things happen. Interestingly enough, participation by migrant health center governing board members in these groups was minimal, although each health center stressed that it kept the board informed and sought board approval of new service or service delivery plans. The case management model which characterized many of the services examined in this study requires the development of coordination agreements that work. Staff observed that when they started to truly manage cases, they were driven to integrate their services with others in the community. The commitment to case management is a critical driving force, and one that brings the concept of community oriented primary care into focus. Active case management in a migrant health center, if it is successful, will ultimately introduce a migrant thread into all community services used by farmworkers with any degree of frequency.

Other Organizations Involved in Coordinated Service Arrangements

As indicated above, a wide variety of local and state agencies and organizations participate with the case study migrant health centers in coordinated or integrated service efforts. Noteworthy are the large number of agreements with state and county health or related departments. In most cases the migrant health center was the lead agency, both in establishing the coordinated service and in its operation. Again, the case studies suggest that the need to manage cases drove the health center to establish coordinating agreements and integrated services.

Another category of organization used by most of the case study sites was universities. Summer projects staffed by students or interns, or even clinical rotations during the year, were cited by six of the case study migrant health centers. Formal agreements

existed with three or more universities in some sites. Relatively few health centers reported important formal agreements to coordinate services with other volunteer organizations, although there were several notable exceptions (e.g., IMC).

Most--but not all-of the case study sites had formal agreements with Migrant Education and Head Start, if these programs were active in their area. All of the case study migrant health centers either provided WIC directly or had integrated services with the agency which provided WIC.

Barriers to Coordination and Integration of Services

Virtually all of the barriers to integrated service delivery reported in the literature were also reported by one or more of the case study sites. Salud, for example, found that the fragmented responsibilities for environmental health were a major deterrent to coordination. MARCHA and IMC reported that the differing program definitions for eligibility of farmworkers made coordination difficult. Several case study migrant health centers noted that most of the other programs offering services to farmworkers considered their own programs to represent "last dollar" coverage, expecting migrant health centers and other organizations to provide services without any inter-organizational transfer of funds.

The full array of complaints about bureaucratic difficulties *were also* cited. Medicaid would not accept income averaging for determining eligibility, which prevented many families from qualifying except for a few pre-season months *or* when expensive tertiary care was required. Some health centers noted that funding guidelines from the Bureau of Health Care Delivery and Assistance (BHCDA) do not provide credit against BCRR standards for some essential preventative services simply because they were not provided during a face-to-face encounter with a clinical professional. If clinical providers spent time organizing and starting up new coordinated/integrated services, maintaining BCRR productivity was a problem unless there was a quick payoff. There obviously is a degree of risk in these activities, but this risk can be contained if the health center is well-run and stable. It also is difficult to coordinate with another organization which is unstable. If the grantee for another program is constantly changing, it is hard to establish and refine working relationships.

Some migrant health centers also brought up the problem of limited service hours by governmental service units (health departments, social service departments, etc.) which were particularly difficult for farmworkers during the harvest season. All sites mentioned the problem of lack of transportation and the difficulty and cost of service coordination among distant service delivery sites. Gaps in funding of services for specific population subgroups were also noted as a problem.

In spite of these barriers, coordinated services have been developed in a large number of migrant health centers. As the survey for the 1991 *Migrant Health Centers Referral Directory* (discussed earlier) indicates, the array of services offered directly by migrant health centers or through formal referral agreements with other service providers is remarkable.

Factors Associated with Success

Although it is presumptuous to attempt to identify on the basis of a brief site visit why each of the case study efforts were successful, and impossible to generalize to the universe of migrant health centers from these disparate examples, some general observations can be made. First, no one management model and no one coordination model characterized all of the case study sites. In general, all of the health centers were mature, stable organizations. All were moving to be or had already been recognized as part of the community.

At least part of the success of the case study migrant health centers may be attributed to non-traditional management. All but one of the Chief Executive Officers interviewed were entrepreneurial and willing to take risks when the odds were reasonable. At the same time, each seemed to have the business management of the health center under control. The boards were not leading; leadership was provided by either the CEO or one or more second-level managers. In several of the migrant health centers the Chief Executive Officer facilitated but did not control the networking and linkage development conducted by department heads. In some ways the "hands-off" management style in several of the health centers allowed a situation in which department heads created the very situation needed to keep their interest, provide non-economic rewards, and contribute to their retention at the health center.

It is important to note that several of the case study health centers mentioned previous failed attempts to develop coordinated services. The ability to learn, to pick oneself up, and try again are important qualities of the 'gutsy" managers at these centers. A migrant health center will undergo significant stress in developing and implementing coordinated or integrated services, and must have the flexibility to respond to and exploit new opportunities, the resiliency to take on new services without damaging the basic program of services, and the perseverance to continue when things are not going well.

All of the case study migrant health centers have developed a level of credibility in the community which has helped in developing coordinated services. This credibility usually comes from a reputation for administrative competence, good financial management, a community board, and the apparent quality and effectiveness of clinical staff and services. Each center appears to be moving to solidify its position as an important community resource rather than just a group serving farmworkers.

Financial Considerations

In general, the case study migrant health centers were successful in obtaining a variety of small grants or contracts to assist with development or expansion of coordinated service arrangements. However, they also took substantial financial risks in many cases. Obtaining limited financing, as with the Salud environmental health services, allowed the center to build an in&structure within the organization and establish external linkages at a low cost to the health center. In several cases these developmen-

tal activities subsequently contributed to obtaining new sources of funding which now fully support the service.

Costs can be kept low through a variety of mechanisms. Several case study sites used summer student placements from the American Medical Student Association, while other health centers dealt directly with health professions, medical, and dental schools for staff augmentation. It is interesting that few health centers fully exploited the potential for external support of their participation as training sites, although faculty appointments as preceptors and participation in student training were fully used in recruitment and retention strategies.

Tri-County maximized Medicaid case management reimbursement in its perinatal program, thereby obtaining financing support for some of its continuing effort to develop coordinated services. (The potential reimbursement was limited, however, by Medicaid regulations which restricted the eligibility of many migrant farmworkers.) Similarly, the community substance abuse prevention program now pays for the support of Tri-County's coalition coordinator. La Clínica, on the other hand, was extremely cooperative with other organizations, to the point where sometimes it gave too much without payment (for example, its willingness to provide physicians to testify in court cases without compensation, participate in training programs, and accept referrals from the health department without compensation). Some payoff from this investment is likely through the El Nino Sano program. MARCHA, through Project NOMAD, was able to cover incremental costs and, at the same time, efficiently arrange for handling of Migrant Education needs and clinic referrals in an organized rational manner. Keystone exploited to the ultimate both a small grant/contract and volunteerism in order to allow it to develop needed services without additional Section 329 funding. Collier found ways to mobilize the county government and a major but distant hospital's self-interest to support its own needs. IMC found that some of the organizations with which it coordinates will not pay full price for services, but will pay a portion. This permits IMC to provide the service to more farmworkers and, through efficient delivery, reduces the actual unit cost of services. Salud's dental program also provided a neat system for capturing all of the Migrant Education and Head Start children in an efficient delivery system. Thus, more children receive dental services than would if Salud were dependent on outreach and parent motivation to bring children in, while at the same time a portion of the costs are covered by the other programs.

With a few exceptions, the total dollar amount involved in each of the coordinated services is small. This speaks well for the ability of the case study sites to accomplish a lot with limited resources. The relatively small dollar value associated with some of these activities belies the fact that many of these arrangements are complex, both organizationally and financially. For example, each organization involved in the coordinated activity has its own fiscal year, overhead rate, reporting requirements, etc., and it was not unusual to find four or more organizations involved.

Impacts and Benefits of Coordination of Services

The big winner in all of the case studies was migrant and seasonal farmworkers. Their health was significantly improved by the various coordinated programs and services documented here. Moreover, more convenient access and greater acceptability in the delivery of these services has generally been a major achievement of the service development. In many cases, services have been added which are not reimbursable by Medicaid or other third party payors. In some cases, the additional services have been acquired through linkage with a program which does not have a specific mandate to serve farmworkers, but which has been willing to do so within the context of a coordinated system for care which serves all segments of the community.

Some of the accomplishments of the case study migrant health centers would be considered outstanding for any rural health agency, let alone an organization established specifically to assist migrant and seasonal farmworkers. YVFC, for example, offers an exemplary integrated mental health and primary care service system which would be a model anywhere in rural America. That this system has the unique sensitivity and capacity for responding to the needs of Hispanics and other minorities on a seasonally fluctuating basis merely adds to the magnitude of the accomplishment. It is reasonable to hypothesize that the outcomes and cost effectiveness of the system, if measurable, would further establish the benefits of these arrangements. The case-managed perinatal services at several of the study sites are also likely to produce improved outcomes, contain costs due to preventable perinatal complications, and ease the burdens of access and compliance with treatment on farmworker clients.

There are also benefits to many of the organizations which coordinate with the case study migrant health centers. State and county agencies are able to better achieve their public health, social service, and/or educational objectives by coordinating or contracting with the migrant health centers. In many cases other organizations have obtained convenient access to primary care for their farmworker clients at little or no direct cost to their organization. There is much credit to be shared when a coordinated service arrangement works.

For the migrant health centers, the benefits can be categorized in several areas:

- Increased visibility and credibility in the community
- Confirmation of their role as providers of unique support services (e.g., the only group offering linguistically and culturally tailored services to the target population)
- Ability to provide opportunities to all levels of health center staff to exercise leadership in the community, achieve personal satisfaction, and build something enduring
- Expansion of services to migrant and seasonal farmworker, with at least some small subsidy beyond Section 329 funds or with an offsetting non-economic gain which enhances the efficiency of service delivery

Condusions

Providers of a variety of other services to farmworkers and to others residing in the migrant health centers' service areas have needs for arranging health care support. These organizations are generally responsive to overtures by migrant health centers to arrange efficient mechanisms for health care, although they tend to see this as a migrant health center responsibility which should be provided at little or no cost to their organization. The coordinated arrangements invariably are beneficial to farmworkers, who then receive more services more conveniently and, in some cases, more effectively.

Although unique local circumstances affected the development of many of the integration efforts studied, most were the products of deliberate and difficult efforts by the migrant health center staff. Most federally-funded health and social service programs have a mandate to coordinate services, but because of the demands for program identity, accountability, separate eligibility and definitions, and reporting and performance standards, there are very real obstacles to developing and implementing coordinated and integrated service delivery arrangements.

Community oriented primary care and case management are concepts which will drive migrant health centers to seek coordination and integration of services. Rural areas have too few resources to support inefficient service delivery, and case-managed service systems will quickly identify the bottlenecks. Arrangements for coordination of services cannot be negotiated in isolation, and migrant health centers must become integral components of the delivery system in their service areas. Planning for community oriented primary care also will benefit horn participation by the larger community. The case study migrant health centers have discovered these truths and have forged the alliances and processes which permit progress toward greater coordination among organizations and agencies.

Community coalition building in order to facilitate development of new services or arrangements to meet high priority health needs is a technique which has not been widely used by the migrant health centers studied. Instead, much of the groundwork for change has come from key individuals who conceived, developed, nurtured, and fought for their programs. Relationships with other agencies and organizations were generally developed through one-on-one negotiations between the health center and other entity.

To the extent that efforts to coordinate and integrate services have been undertaken to maximize the services provided to farmworkers, they have largely achieved this objective. These activities have also helped to legitimize the presence and role of the migrant health center in the community, an achievement with potential long-term benefits to the health centers. Among the case study migrant health centers, Migrant Coordinating Councils played a variable role, with several of the centers working around an ineffective council, or without benefit of a council. Some means for identifying and assisting in renewal or redirection of ineffective coordinating councils is needed.

Providers of a variety of other services to farmworkers and other persons residing in the migrant health centers' service areas need to arrange for health care support. These organizations are generally responsive to overtures by migrant health centers, or may initiate overtures on their own to arrange efficient mechanisms for health care; however, they tend to see primary medical and dental care as a migrant health center responsibility which should be provided at little or no cost to their organization. The coordinated arrangements invariably are beneficial to farmworkers, who receive more services more conveniently and, in some cases, more effectively.

An intuitive understanding of concepts such as fixed and variable costs appears to have helped some health centers negotiate deals which result in an expansion in funds for health services or in the services provided for fixed funding levels. However, sophisticated financial skills are not characteristic of migrant health centers. Instead, these health centers tend not to know what their unit costs truly are, not to have done "product line costing," and to set prices which benefit the patients but do not necessarily achieve strategic objectives. There may be good reasons for migrant health centers to negotiate arrangements which appear to "give away" their services to other agencies, but we cannot rule out the possibility that this represents an investment or "loss leader" to capture market share. In any event, migrant health centers appear to consistently arrive at arrangements which benefit their farmworker patients.

Successful migrant health centers have management which is problem-driven, and which converts problems into opportunities. Developments documented in the case studies often required diligent efforts by individual staff members who persevered for prolonged periods to develop resources to fill gaps in the service continuum. The case study sites were good at obtaining grants and contracts which allowed them to expand services, but with a few notable exceptions have been slow to realize opportunities for obtaining remuneration for services provided. This may also reflect the absence of "business" technical assistance through the BHCDA technical assistance contracts.

Although most of the case study migrant health centers successfully coordinated with public health departments, these efforts did not have a broad community oriented primary care focus. Arrangements with health departments tended to center on specific issues such as perinatal services or AIDS testing. Few case study sites had achieved active collaboration with growers on broad issues, although several were working with growers on specific identified needs.

The scope, magnitude, and sophistication of integration and coordination of services in the 103 migrant health centers in the U.S. varies tremendously among centers and between sites located in different communities. The following items summarize the conclusions of this study:

- Few current federal incentives promote the development of service coordination.
- Most service coordination efforts must be initiated and nurtured by the migrant health centers or they simply will not take place.

- commitment of additional staff and resources is required in the initial developmental phases of a new coordination effort. On-going maintenance of such an effort is required to elevate coordination to the level of true integration.

- Service coordination and integration efforts appear to increase cost efficiency, enhance productivity, decrease provider burnout, and increase patient satisfaction.

- Interagency coordination promotes provider collaboration, increases support and colleagueship, promotes the development of other strategic alliances, enhances community acceptance, and acts as a stabilizing factor for the operations of all participating organizations.

- Coordination and integration of services by migrant health centers increases community awareness, acceptance, and public support for the migrant and seasonal farmworker population. Such efforts enhance both recruitment and retention efforts for professional provider staff for the following reasons:
  - increased staffing and flexibility;
  - increased health center capacity;
  - increased number and type of services provided;
  - increased institutional pride;
  - increased community awareness of provider achievement;
  - increased opportunities for career development;
  - opportunity for strong nursing roles in community oriented health care;
  - positively position the health center for more effective advocacy;
  - increased clinical leadership opportunities for provider staff;
  - coalesce the health center and the community in a team effort and reduce divisiveness by implementing joint vision.

Multiple barriers exist for migrant health centers in the integration and coordination of services. Barriers can be broken down roughly into local, state and/or regional, and federal levels. One local factor which affects the relative success of these efforts is the overall availability of community resources. Migrant health centers which begin to integrate services in frontier or scarcely populated rural areas face a very different challenge from the larger 330/329 centers located in more suburban surroundings. Other local factors which can either facilitate or present barriers to coordination include:

- Age, size, relative stability and community image of the migrant health center

- Reputation and communication/negotiation skills of the Executive Director, Medical Director and other key personnel
- Grower support
- Support and vision of the migrant health center board of directors
- Discretionary financial resources of the migrant health center which can be allocated for developmental and organizational efforts
- Adequacy and stability of the professional provider staff, particularly the physicians
- Overall commitment of the migrant health center to the concept of case-managed care.

State and regional level factors which influence the development of integration and coordination of services include:

- Balance between need and general resource levels
- Focus on and commitment to the farmworker population
- State eligibility requirements for public services such as Medicaid and Workers Compensation
- Support from and effectiveness of the state primary care association
- Overall level of interagency collaboration within the state
- State-based incentives for service integration efforts

Factors at the federal level which impede the development of integrated service arrangements center around resource and policy issues:

- Funding policies which prioritize traditional medical care over non-reimbursable efforts, creating very real disincentives for commitment of funds necessary to initiate integrated services
- Lack of available dollars with the flexibility to support creative demonstration efforts
- Lack of technical assistance which would allow migrant health centers to establish optimal fiscal positioning and thus to have adequate resources to focus on interagency coordination and other collaborative efforts
- Programmatic isolation among federal agencies, which does not encourage creation of linkages from the top down

Recommendations for Migrant Health Center Staff and Boards

Migrant health center governing boards should view coordination of services as an intermediate goal and comprehensive integration of services as a long-term goal. They must be prepared to provide direction, based on their understanding of current community opportunities, to help the health center meet those goals. Health center staff must be given sufficient resources and flexibility in order to successfully organize, implement, and maintain integrated efforts. It is crucial for the migrant health center's board of directors to give the Executive Director freedom to implement their direction, even if it means taking risks on behalf of the corporation in order to overcome previously described barriers. The need to take calculated risks must be recognized and supported, even if the short-term outcomes are not successful.

Migrant health centers should be encouraged to adopt a more business-like approach to service integration efforts. Specifically, migrant health centers should adapt private sector techniques where appropriate, develop written interagency agreements which reflect up-to-date arrangements for involved parties, and document their experiences from one year to the next. This will help institutionalize a plan for continuity of coordinated service.

Migrant health centers' financial officers should monitor cost data with respect to each of their service agreements, including developmental costs, in-kind contributions of each agency involved, revenue, and savings. Clinical and administrative staff should implement systems for tracking and evaluating outcomes of coordinated services in order to provide a context for cost effectiveness assessments. Migrant health center boards of directors could play a pivotal role in identifying opportunities, enhancing health center position and image within the community, and providing sound business advice.

Recommendations for Federal Officials

In order to support the original intent of PHS 329 authorizing legislation, it is crucial that migrant health centers be given adequate incentives, flexibility, guidance, and comprehensive and on-going technical assistance. Significant rewards need to be given for those grantees who leverage additional resources through coordination and integration of community services on behalf of migrant and seasonal farmworkers. Such efforts cannot operate on an "on again, off again" basis, affected by changes in each year's funding priorities.

In order for these health centers to function successfully as integrated service delivery systems, the Migrant Health Rogram must become an effective advocate for the utilization of current resources and provider time to be devoted to the creation of these linkages. Strategic alliances developed and sanctioned at the federal level will send a

message and act as models for state and local initiatives. Guidance material and policies issued by the Public Health Service should contain language which supports entrepreneurial achievement. Actual implementation of such policies should reward rather than penalize health centers for entrepreneurial creativity which clearly serves the best interest of the target population.

A comprehensive, coordinated technical assistance initiative which focuses on building successful businesses of each migrant health center should be created and made available as long-term support. Strategic planning for coordination of services can be assisted through the development of self-help materials and checklists. A list of candidate services can be used to identify gaps and strengths/weaknesses in coordinated services. Migrant health centers are often the only group in the community to offer culturally sensitive and relevant services, and they should be trained to take advantage of this niche in their marketing efforts.

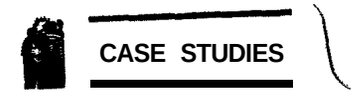
Provider productivity figures must be reviewed in light of the fact that it is imperative for migrant health centers to be allowed to use key provider staff in leadership roles to forge these alliances.

Recommendations for Other Organizations Sewing Migrant and Seasonal Farmworkers

It is important for other organizations and agencies to recognize farmworkers as an integral part of the community they serve, even if the farmworkers are only present for part of the year. PHS 329 funds were never intended to be the sole-or even the primary-source of health care for farmworkers; rather, they were intended as a migrant-specific adjunct to local health care delivery systems. The realities of federal Migrant Health funding (roughly $100 per user per year for 12 percent of the total population) support the premise that the Migrant Health Program cannot be the sole source of care for farmworkers.

In view of the fact that service fragmentation is neither cost effective nor particularly satisfactory from a patient standpoint, coordination and integration must occur.

All organizations serving the migrant and seasonal farmworker population should recognize the need for effective advocacy on behalf of these at-risk, hard-to-reach, and challenging clients. The use of a case management approach will facilitate the development of collaborative and integrated services. Agency flexibility, good will, and colleagueship will enhance cost effectiveness and can allow each organization to more fully implement its mission.


CASE STUDIES

Integration and Coordination of Services at Migrant Health Centers

Case Study Reports

Collier Health Services
Immokalee, Florida

Background

Collier Health Services, Inc. (Collier) is funded under the authority of both section 329 and 336 of the Public Health Services Act, which supports migrant and community health center activity. The Collier model for delivery of health care is that of a fully staffed year-round medical facility. The main clinic facility and administrative offices are located in Immokalee, Florida, a designated health manpower shortage area and a medically underserved area.

Although a greater number of migrant and seasonal workers are served from September through May when the bulk of the planting and harvesting of vegetables and citrus occurs, the Immokalee area remains the year-round home base for the families of many migrant workers who move "upstream" during the summer months. This is borne out by the monthly average of 1,330 migrant and seasonal workers and their families who received medical services during the months of June, July, and August 1989. This compares to the monthly average of 1,736 for migrant and seasonal users for the other months. Of 20,000 clinic users during 1989, about 12,000 were migrant and 2,000 were seasonal farmworkers. About 87 percent of all clinic users in the first half of 1990 had incomes below the poverty level; 11 percent had incomes between 100 percent and 200 percent of poverty, and 2 percent had incomes over 200 percent of poverty. The ethnic composition of the clinic user population is 5'7 percent Hispanic, 25 percent non-Hispanic White, 10 percent non-Haitian Black, and 8 percent Haitian.

Immokalee is located 50 miles from the gulf coast metropolitan areas of Naples and Fort Myers. Miami is located 100 miles to the east. The Immokalee area produces over 90 percent of the winter tomatoes for the eastern U.S. Bell peppers, cucumbers, watermelons and citrus fruit are also harvested in great numbers from November through May.

Immokalee is a growing area. The 1966 Rimary Care Planning Committee, chaired by Collier's Chief Executive Officer, was formed to, among other things, determine the extent to which the anticipated expansion of citrus acreage and associated demands for farmworkers would impact on the health care needs of the area. The estimate at that time of 75,000 to 105,000 acres planted by 1990 that would draw their labor supply

from Immokalee, has been greatly exceeded. About 150,000 acres of citrus trees are planted, although not all are bearing fruit yet. Permits have been obtained for several thousand additional acres to be planted. It is estimated that, just for maintaining the groves and harvesting, an additional 23,000 workers will be required by 1995.

Organization and Staffing

Collier is governed by a nine-member board, which includes six board members who are users of the health center. An organizational chart of the health center is shown as Exhibit 1. Collier is headed by a Chief Executive Officer who has been with the health center since 1930. Other administrative staff include a Deputy Director and a Chief Financial Officer. The clinic staff includes eight FTE physicians (including internists, pediatricians, family practitioners, and an obstetrician/gynecologist); four mid-level practitioners (nurse practitioners, nurse midwives, and physician's assistants); and 1.3 FTE dentists.

A major administrative focus in the past year has been revenue maximization. Medicaid revenues have gone up dramatically (from $600,000 to $1.7 million in one year) since Collier began routinely checking eligibility on the statewide computerized system. The project is trying to get an on-site eligibility worker. The health center is also responsible for a migrant insurance program that covers 2,200 enrollees. Blue Cross/Blue Shield is the intermediary for this program, which now only pays for upstream care.

Coordination with Community Hospital

Description

Collier Health Services has an excellent relationship with Naples Community Hospital. This relationship is characterized by the coordination of a range of services in a way which benefits both organizations:

- A lab services agreement, which is informal in that there is no counting of the number of lab tests and no limit on the number of tests provided.
- The hospital will own a new 40,000 square foot clinic building and rent space to Collier Health Services.
- The hospital, through Community Health Care, Inc. (CHC), provides staff for the Urgent Care Clinic at Collier Health Services.
- Naples Community Hospital accepts all of Collier's patients and treats them well. The hospital has people on its staff who speak several languages.
- The hospital will pay Collier Health Services' share of the cost of a Medicaid eligibility worker to be stationed at the health center by the State of Florida

Department of Health and Rehabilitative Services. According to the written agreement between the State and Collier Health Services, Collier's share, $17,069, is half of the estimated total cost.

- Collier Health Center also has a good relationship with the radiology group in Naples. The group limits the clinic to two free slots per day and takes all other patients with coverage at any time.

- None of Collier Health Center's staff have admitting privileges at Naples Community Hospital because the hospital bylaws require that admitting physicians be 20 or less minutes away. However, in the past Collier physicians have participated in continuing medical education at the hospital, as well as at the Veterans Administration out-patient clinic in Fort Myers.

History

The people in Immokalee have wanted a hospital for a long time because Naples Community Hospital (50 miles away) is the only hospital in the county. The health center decided to focus its limited resources on primary care (e.g., hypertension, diabetes, OB), but in order to do this Collier had to close its emergency room. The community protested to the county commissioners, The county commissioners voted to keep the Urgent Care Clinic and give financial support to Collier for the provision of urgent care services. The county also pressured the Naples Community Hospital to do something in Immokalee. Naples Community Hospital, through Community Health Care, Inc., now provides staff for the Urgent Care Clinic at Collier Health Services, with the county providing financial support through Collier. Thus, Collier maintained its emergency services, but obtained additional county funding and staffing provided by Naples Community Hospital.

The hospital is well endowed and very aggressive about taking advantage of new opportunities. As the only hospital in the county, the hospital accepts its obligation to serve all residents, but prefers to do this with a minimum of government red tape. The hospital defines its community as all of Collier County.

An earlier example of coordination was the White Elephant store. Collier Health Services used to operate a branch of Naples Community Hospital's white elephant store in Immokalee. The store is no longer operated because it is very hard to get volunteers to work in the store in Immokalee.

Operations

The' hospital's lab service picks up laboratory specimens daily at Collier Health Services, calls with results for urgent matters, and has installed a computer printer on site for reporting results.

The staff of the Urgent Care Clinic are employees of Community Health Care, Inc. (CHC), a separate company set up by Naples Community Hospital for this purpose.

The hospital provides recruiting and staffing of the medical team through a written agreement between Collier Health Services and CHC. Collier Health Services' Medical Director supervises the Urgent Care Clinic medical team.

Collier Health Services gets a check from the county for urgent care services, and uses this money to pay CHC. There is a formal written agreement between Collier county and the health center for urgent care services. Under this agreement, the county provides funds for a medical team consisting of a physician, nurse practitioner, and translator/aide. The county also pays for pharmaceuticals, up to $7.50 per urgent care patient treated. The county's payment also covers costs of malpractice insurance for the medical team and of the shuttle used for patient transportation. The one-year renewable agreement also stipulates that Collier county will establish and administer a trust fund to collect private contributions to offset costs to the county for the Urgent Care Clinic.

The entire health center space, including the urgent care clinic, is currently leased from the county. Collier Health Services provides the following for the Urgent Care Clinic: x-rays, lab tests, medications, medical records, patient registration, and triage. Costs of medications in excess of $7.50 per patient are covered by Collier Health Services, and the health center must obtain and pay for the necessary malpractice insurance to upgrade the institution from regular to urgent medical care.

Impact/Benefits

The arrangement for laboratory tests is beneficial to both parties. Naples Hospital has opened a lab operated for profit by Diagnostic Services, Inc. (DSI). DSI wants to have all of Collier county's laboratory business. Collier Health Services is large enough to make trips to Immokalee worthwhile—this allows DSI to offer laboratory services to smaller providers in that part of the county as well.

Overall, the hospital is the health center's ally in assuring that patients get all of the referrals they need (the cost of referrals is another donated cost). To be on the staff of the hospital, physicians are required to do a rotation in the hospital's emergency room; therefore, they see and accept into their practice for specialty care Collier Health Center's patients.

Costs/Financial Savings

Many of the benefits of this relationship are not readily quantifiable. Exhibit 2 documents costs and resources provided by the cooperating organizations to the extent possible. The cost for laboratory services is a flat fee of $40,000 ($44,000 in 1991) paid by Collier Health Services to Naples Community Hospital. For this fee, the hospital's reference lab does all of Collier's outside lab tests. Since the arrangement involves a set fee, Collier does not track the number of tests sent or their market value. However, Collier' Executive Director and Chief Financial Officer both agree that this arrangement provides substantial savings for the health center.

Collier Health Center does not pay the hospital for visits to referral physicians. According to its 1990 Annual Report, Naples Community Hospital provided $16 million (in charges) in uncompensated care. At least 60 percent of this amount is estimated to be for Immokalee residents. In addition, an estimated $14,000 in physician fees per year are uncompensated.

The rent Collier Health Services will pay Naples Community Hospital for the new clinic space is estimated to be $50-60,000 below market value.

Lessons for Other Migrant Health Centers

Although other institutions in the community may have very different perspectives and goals, partnerships can be formed by identifying objectives/projects that benefit both organizations.

Coordination with Medical School

Description

Collier Health Services has an established relationship with Southeastern University of the Health Sciences, College of Osteopathic Medicine. The success of this relationship is based on the commitment of both organizations to rural health and primary care. Collier Health Services is a rural health training site for the school's residents and medical students. Collier's physicians serve as preceptors to the medical students, and have faculty appointments at the medical school. Through the Area Health Education Center (AHEC), the medical school can provide the health center with materials for continuing professional education, such as library materials, computers, and software. The residents and medical students are currently housed in a trailer on the clinic site. Collier has involved the medical school in planning for the new clinic site, which will include housing for residents and students and a space for optometry services.

History

Southeastern University College of Osteopathic Medicine was founded in 1979. In 1981, the school took its first class of 40 students. There are now about 100 students per class. The purposes of the school are directly related to its southern Florida location: to provide Doctors of Osteopathy for the southeastern United States, to train good family/general practitioners (almost all of the courses offered are required), and to provide an emphasis on rural medicine, geriatrics, and minority medicine. The program includes an 18-hour required course in rural medicine, with a compulsory rural rotation of **at least one month. However, 60 percent of the class** takes a three-month rotation. Collier Health Services is part of the three-month rotation program.

In 1986, the pharmacy school was started, offering Bachelors and Doctorate programs with an emphasis on primary care. The university now has an Optometry School and Allied Health School (which trains physician's assistants and physical therapists), so it is now a university of the health sciences.

The College of Medicine worked with the state Area Health Education Center (AHEC) from the beginning on developing rural residency training. Both the AHEC and the federal Rural Health Program partially support the residency program.

Operations

The medical school sends one resident and three medical students on three-month rotations to Collier Health Services year-round. The residents live and work in Immokalee. The residents and medical students are supervised by Collier's Medical Director. Residents and students see patients and participate in case conferences and continuing medical education programs. Residents and students also provide weekly lectures for in-house staff at the health center.

The AHEC provides libraries/computers and software at training sites such as Collier Health Services (e.g., interactive case management, Grateful Med, drug information service database).

Impact/Benefits

The benefits of this program are apparent to both organizations. Collier Health Services believes the services of the residents and students, as well as the continuing education activities, improve the quality of care provided by the health center. Collier has managed to overcome some of the disadvantages of its remote location through its relationship with the medical school. This association has provided professional contacts, stimulation, and resources for its medical staff.

The medical school provides the health center with about 1.5 FTEs per year. Collier's Medical Director estimates that the average resident sees 150-200 patients/month. There are many case conferences and educational opportunities for both the students and the center's medical staff. While there is a trade-off of time between patient care and professional relationships, the medical school relationship is considered to be a key to retention of the current medical director at Collier Health Services.

For the medical school, Collier provides an excellent educational opportunity for its students. The quality of the preceptorship is excellent, the caseload is varied and demanding, and the staff make the students feel comfortable in the community.

Costs/Financial Savings

Exhibit 3 presents financial information on this cooperative effort. A written letter of agreement between the medical school and Collier Health Services provides for a

$30,000 payment to Collier for providing the formal training program for residents and medical students. The salary costs for residents end expenses for housing transportation and subsistence are provided by the medical school. Collier Health Services accounts for the time of the residents and medical students as in-kind services, using a rate of $35 per hour for medical students and $50 per hour for residents. The Medical Director of Collier Health Services spends approximately 20 percent of his time as a preceptor for this program.

Lessons for Other Migrant Health Centers

In some situations it may be desirable to look beyond the immediate community or county for mutually beneficial relationships, and to take a long-term view of potential benefits. These two organizations are a natural partnership due to common health service interests. Over time, Collier Health Services has become an advocate of the university in the Naples/Collier county medical community, and the university has been able to offer new benefits to the health center as its programs have expanded.

Recommendations

Collier Health Services is doing an excellent job of positioning itself for the future growth anticipated in the area. The health center has pursued promising opportunities for collaboration, but other opportunities have yet to be tapped. For example, dental services and funding for dental services are still inadequate. It is recommended that Collier investigate the availability of Migrant Education funds for providing dental services to children. Another source of support to be investigated is the Rural Hospital Program.

Exhibit 1

Collier Health Services, Inc.
Organizational Chart

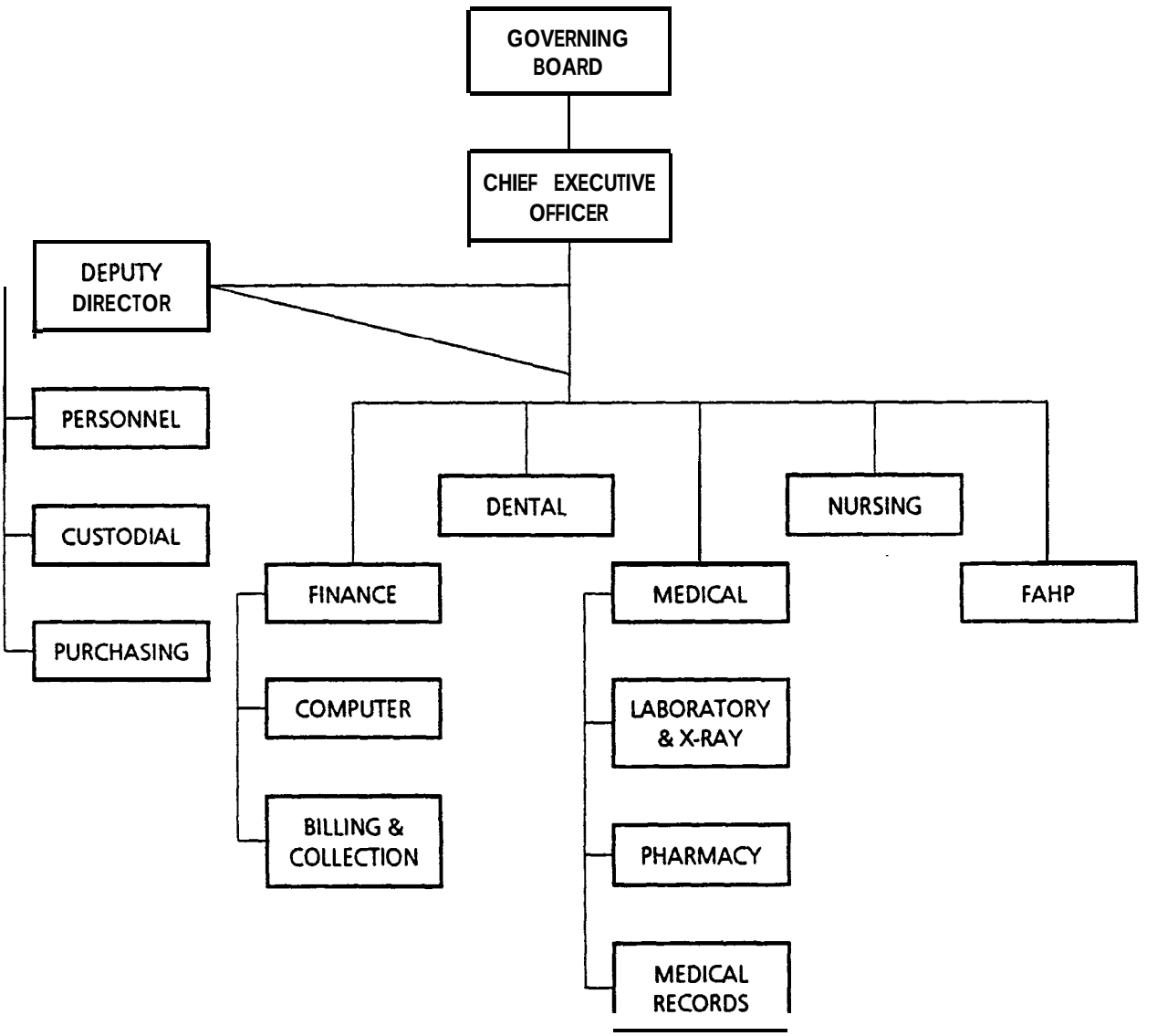


Exhibit 2

Collier Health Services
Coordination with Southeastern University College of Osteopathic Medicine: Integrated Services Cost

Resource Category	Collier Health Services	SECOM/AHEC*	Total
Personnel			
Residents (1)		$ 41,600	$ 41,600
Medical Students (2)		$ 52,000	$ 52.000
Medical Director (3)	$ 20,008		$ 20,008
Formal Training Module (4)		$ 30,000	$ 30,000
Supplies and Equipment (5)		Not quantified	
Computers			
Software			
Professional texts			
Periodicals			
Office Space – Students	Not quantified		
Student Housing, Transportation, and Subsistence (6)		$ 3,000	$ 3,000
TOTAL	$ 20,008	$ 126,600	$ 146,608

SECOM receives funding from the Area Health Education Center (AHEC) to support the rural residency training program and professional education activities.

(1) Based on .5 FTE at $40/hour (source: Collier Health Services Continuation Grant Application for 4/1/91–3/30/92).

(2) Based on 1.0 FTE at $25/hour, as estimated in grant application.

(3) Based on 20 percent of Medical Director's salary plus 22 percent fringe benefits.

(4) A letter of agreement between Collier Health Services and SECOM provides for a payment of $30,000 to Collier for a 'formalized training module" for medical students and residents. This payment may cover staff time, space, and/or supplies.

(5) Professional education materials provided by the AHEC through SECOM. Amounts not quantified.

(6) Estimated at $5/student or resident per day plus round-trip transportation from Miami.

Exhibit 3

Collier Health Services Coordination with Naples Community Hospital (NCH): Integrated Services Cost

Activity/Resource Cetegoty	Collier Health Services	NCH-Diag. Svcs. Inc. (DSI)	NCH-Comm. Health Care	Naples Cty. Hospital	Collier County	State Dept. of Health & Rehab.	Total
Laboratow services (1)	$ 44,000	not quant.*					$ 44,000
Urgent Care Clinic							
Personnel (2) - Physician, Practitioner, Translator/ Aide					$ 225,000		$ 225,000
Pharmaceuticals (3)					$ 49,000		$ 49,000
Malpractice insurance - Urgent Care medical team					rot quant.*		
Patient transportation (4)					$ 12,300		$ 12,300
Support facilities and services (5): space, x-rays, laboratory tests, medical records, patient registration/triage, medications	$ 164,356						$ 164,356
Staff recruitment			not quant.'				
Supervision	rot quant.*						
Malpractice insurance - facility	rot quant.*						
Other: On-site Medicaid Eligibility Worker (6)							
Salary				$ 9,277		$ 9,277	$ 18,554
Benefits				$ 3,162		$ 3,162	$ 6,324
Travel/Expenses				$ 3,720		$ 3,720	$ 7,440
Equipment				$ 910		$ 911	$ 1,821
TOTAL	$ 208,356	$ 0	$ 0	$ 17,069	$ 286,300	$ 17,070	$ 528,795

.) For a flat fee of $44,000 n 1991, DSI provided unlimited reference laboratory services for the health center. Since the arrangement involves a set fee, neither Collier Health Services nor DSI tracks the number of tests sent or their market value.

(2) Based on $80–90 per hour for 10 hours per day for urgent care medical team.

(3) Based on $7.50 per urgent care patient treated.

(4) The county funds a patient shuttle provided by Florida Preschools, Inc. d.b.a. Yellow Cab Company of Naples, Inc.

(5) This is a maximum amount for the listed support services. Medication expenses are those in excess of the $7.50 per patient billed to the county.

(6) Source: Agreement between State of Florida Department of Health and Rehabilitative Services and Collier Health Services. Costs are shared equally between HRS and site sponsor-

* Actual amounts are not available or are not qualified, but are shown to indicate that resourcesa re provided.

El Progreso del Desierto, Inc.
Coachella, California

Summary

El Rogreso del Desierto, Inc. (El Rogreso) is a community/migrant health center which was incorporated in 1976 to provide health and social services to low income individuals and migrant and seasonal farmworkers in the rural agricultural communities of the eastern Coachella Valley in Southern California. El Rogreso provides comprehensive health and social services in a fully staffed, year-round, primary care model. The health center's scope of services includes medical, x-ray, dental, optometry, health promotion, disease prevention, health education, nutrition counseling, family planning, child wellness, perinatal, and outreach services. The center has two locations, its main clinic in Coachella, California, and a second site in contiguous Indio, and also operates a migrant day care center.

El Rogreso has aggressively developed collaborative and interagency relationships within its service area in an attempt to overcome the traditional resistance of agencies and hospitals to respond to its targeted population. Since El Rogreso is an hour and one-half drive from the county hospital and from health facilities at the county seat, the health center is confronted with an on-going struggle to provide hospital access for its patients at the several private hospitals in the Coachella Valley. El Rogreso primarily accomplishes this access through one-on-one relationships with physicians and physician groups. The center further pursues enhancement of these relationships through coalition building and cooperation with other community agencies.

The integrated services studied at the site visit are the Human Immunodeficiency Virus (HIV) services and related substance abuse prevention efforts of the health center. Of particular interest is El Rogreso's participation in the Coachella Valley AIDS Consortium (CVAC). El Rogreso has played a leadership role in the development of interagency agreements, and, as a partner in CVAC, is able to provide comprehensive primary and secondary specialized services to HIV-positive clients. With the thirteen other current consortium members, El Rogreso has formed an education committee to coordinate activities, share education strategies and programs, and work with school districts on school-based education initiatives. Much effort has been placed on the coordination of activities through the consortium to avoid duplication of effort and maximize dollar resources. The vision of the consortium is to provide equal access to quality service delivery for the prevention and treatment of HIV disease.

In addition to El Rogreso's participation in the Coachella Valley AIDS Consortium, the clinic itselfhas an active HIV/substance abuse program. This program has received funding from the California Department of Health Service's Office of AIDS, and focuses on community education preventive services to high risk youth, a bleach program for minority patients, and an education program targeted on HIV issues for migrant farmworkers and their families. While this program has minimal funding, it is particularly active in community education and in developing cooperative and inte-

grated resources. As part of its strategy to target the teen high risk population, El Rogreso has developed a teen dramatic theater that visits schools and community groups with HIV and safe sex dramas, as well as stop smoking drama and "rap" songs. This program, called Teen Teatro, has been particularly well-received by the youth community of the Coachella Valley.

In general, these activities are evidence that El Rogreso intends to stay on the leading edge of HIV/substance abuse issues, particularly as they relate to the farmworker population.

Background

El Rogreso is located in an arid, irrigated, agricultural region of southern California, on the eastern boundary of the state some 100 miles from the Mexican border. As a fully staffed, year-round health center site, El Rogreso provides a comprehensive range of services including perinatal, dental, and optometry services, as well as social and psychosocial services and referral networks. El Rogreso serves a population of about 18,000 patients. The ethnic breakdown of the patient population is about 93 percent Hispanic, 3 percent White, .05 percent Black, and 2 percent other ethnic backgrounds. The clinic user population is growing at the rate of about 10 percent per year. Approximately 82 percent of clinic users have incomes below the poverty level; 15 percent have incomes between 100-200 percent of poverty; and 3 percent have incomes over 200 percent of the poverty level.

Organization and Staffing

El Rogreso functions with an annual operating budget of $4 million. The present staff of 100 employees includes four FTE physicians, three FTE nurse practitioners (including one specializing in Obstetrics/Gynecology), two and one-half FTE part-time physicians, one FI'E dentist, one FTE optometrist, one-half FTE x-ray technician, four FTE health educators, and one FTE nutritionist. El Rogreso's Board of Directors is made up of twelve community members, seven of whom are users of services at El Rogreso.

Administrative operations are primarily handled by a five-person administrative team which includes the Executive Director, Associate Executive Director, Director of Community Health Services, Finance Director, and Medical Director. Currently, the Executive Director position is vacant; the Associate Executive Director serves in an acting capacity. Operations are largely decentralized, with program directors and department heads in all areas accepting responsibility for day-to-day operation of their areas. The Director of Community Health Services oversees the preventive health and social services, HIV/substance abuse education programs, and community outreach. The Medical Director oversees direct clinical services, including the dental and optometry programs. The primary care site in Coachella is a typical ambulatory care clinic, where a majority of the health services are delivered. The second delivery site in Indio, which is not funded by the federal Migrant Health Program, currently houses the comprehensive perinatal program, as well as the offices and activities for commu-

nity outreach, social services, and health education activities. Due to space limitations, administration, dental, and optometry currently share office space in a third off-site building within several blocks of the primary clinical facility.

HIV Services

Description

The HIV Program at El Progreso consists of coalition building, health education and street outreach, HIV testing and counseling, case management, AZT treatment, basic medical treatment, and referral as needed for more specialized care. Although the number of AIDS patients at Coachella is small (fifteen clinic users were HIV-positive in FY 1990), the clinic staff have already seen the extensive resources required to treat these patients and their families. Furthermore, the high rate of sexually transmitted diseases in the clinic population indicates the need for HIV testing, education, and counseling, and, in all probability, indicates that the number of HIV-positive patients will increase in coming years. Since the resources needed to address AIDS in the Hispanic community are almost nonexistent, El Progreso staff felt their involvement in the area HIV consortium was extremely important in preparing for future needs of their clinic population.

The clinic and CVAC subscribe to a "trans-agency approach" to providing comprehensive care and continuity of services without duplication of effort. Service delivery goals of the consortium include the enhancement of primary care services so that waiting times for appointments do not exceed 7-10 days; the development of a local alternative delivery system for primary care, including in-patient and out-patient services; increased accessibility of nursing home beds for persons with HIV infection; expansion and enhancement of access to transportation services for HIV-infected individuals in the Coachella Valley; and ensuring the availability of appropriate mental health services for persons with HIV infection.

El Progreso has developed integrated relationships with the following organizations for serving HIV patients:

- Loma Linda Hospital
- Riverside County Health Department
- Catholic Charities (particularly for social service resources)
- The Desert AIDS Project
- Eisenhower Medical Center, Rancho Mirage'
- The Housing and Urban Development Authority
- Riverside County Department of Drug Abuse

History

The Coachella Valley AIDS Consortium began in 1987 as an informal network of providers interested in sharing information and identifying resources for their HIV-positive clients. Representing one of the five founding organizations in the consortium, El Progreso staff have played a leadership role in advocating for culturally and linguistically appropriate services for their patients. The Consortium received a two-year grant from the Irvine Foundation, a regional California foundation.

Operations

The consortium is a private, not-for-profit California corporation. Participating public and private entities include hospitals, the county health department, the county Social Security Administration, El Progreso, and the Desert AIDS Project. The primary objective of the Consortium is to assure access for high risk populations and county-wide coordination of services. Exhibit 1 depicts the delivery systems coordinated through the consortium.

Pre-and post-test counseling and the drawing of blood samples for HIV testing are conducted by Coachella staff. The health center contracts out for the actual lab tests at a cost of $12.50 per test. El Progreso is reimbursed at $35 per test by the Rural Health Office of AIDS. In the year ending June 30, 1991, 212 HIV tests were provided at Coachella.

The health center is also participating in a study being conducted by the University of California, Irvine entitled, "AIDS Prevention for Migrant Workers: An Evaluation." The study will test the effectiveness of TV, radio, and other educational materials for AIDS prevention.

Impact/Benefits

Participation in CVAC has enabled El Progreso to speak on behalf of the Latino and migrant farmworker populations, and to assure that the needs of these populations are recognized in county-wide decision making and policy and services development. Some direct benefits to El Progreso's patients can already be identified. For example, before the Desert AIDS Clinic opened, the efforts of the Consortium resulted in an agreement between CVAC and the Riverside County Health Department to provide one day per week of AIDS primary care services at the Palm Springs Health Center. The Social Security Department trained one person in eligibility for HIV services. For the long term, the consortium provides El Progreso a significant opportunity to access care, coordinate care, and maintain a high level of quality of care for persons who become HIV-infected.

Familias y SIDA, a direct outgrowth of CVAC efforts, is a local coalition consisting of organizations such as Catholic Charities, the Riverside County Health Department Early Intervention Office, the Riverside County Drug Abuse Program, and the Visiting

Nurse Association. The purpose of this coalition, which is continuing to thrive as a source of psychosocial support independent of CVAC, is to coordinate services and health education for Hispanic substance abwe and HIV patients. On a day-to-day basis this coalition is helpful, not only for these patients and their families, but also for the broader patient population served by El Progreso. Catholic Charities provides funding to Familias y SIDA for the services of a Spanish-speaking psychosocial counselor. El Progreso staff continue to participate in a task force/work group of substance abuse providers, which was also an outgrowth of the consortium.

A second coalition, Coalición de Recursos, is an active regional coalition providing integrated referral and service opportunities for Hispanic farmworkers. This coalition has published a resource book in Spanish identifying all of the participating organizations that serve migrant and seasonal farmworkers for legal services, immigration, health care, education, and nutritional services. While the consortium has been successful in bringing resources for AIDS treatment to the community, El Progreso also serves as a resource to other members of the consortium by serving Spanish-speaking clients.

Costs/Financial Savings

Exhibit 2 lists the activities and resources included in our review of El Progreso's coordinated HIV-related activities. Exhibit 3 displays the costs and sources of funding for these activities. All references to costs exclude the Indio site, since it is not a federally-funded migrant health center. As evidenced in the above discussion of impacts and benefits, many positive aspects of these activities are not readily quantified, Furthermore, this activity is based on a long-range view of the service needs of its population. It is probable that the benefits of these activities will not be realized for a number of years.

lessons for Other Migrant Health Centers

This activity is facilitated by the Interim Executive Director's recognition of the value of coalition building. His support of this activity, and the commitment of the Director of Community of Health Services to these efforts, are keys to success.

El Progreso has employed a forward-thinking strategy which can be instructive to other health centers. For example, the concept of trans-agency coordination of care is particularly appropriate to the populations served by migrant health centers, since providers must often address psychosocial, housing, transportation, and other needs in addition to health services. These efforts also provide access to specialized secondary services for the Hispanic population. El Progreso is showing that a migrant health center can be a 'pioneer" in its community by developing an infrastructure that provides for comprehensive care and case management. The health center is also on the leading edge in its serious commitment to health education and development of innovative approaches to prevention.

A final lesson to be learned is that of persistence. While not necessarily welcomed as a major player in the CVAC at first, staying the course with the consortium is paying direct dividends to El Rogreso in its involvement in spin-off initiatives, such as the substance abuse task force, Familias y SIDA, and the perinatal consortium. The health center is positioning itself for the future.

A note of caution is that services for HIV require a tremendous commitment of time and resources. A balance must be struck in order to prevent derailing other essential services and potentially hurting the health center's credibility in the community. This requires a careful analysis of the demographics and health needs of the community and thoughtful priority-setting.

Recommendations

It is extremely important that coalition building activities be well documented, including presenting a clear picture of the infrastructure being developed, end flow-charting the planned referral system. Interagency agreements should be documented at least in informal correspondence; and interagency quality assurance, resource development, case management, and tracking should also be documented.

The health center should be involved in developing the protocols at each of the participating agencies in order to address assurance of follow-through on referrals, assurance of patient follow-up, clarification of liability issues, and assurance of patient confidentiality.

Exhibit 1

Coachella Valley AIDS Consortium Project: Delivery Systems

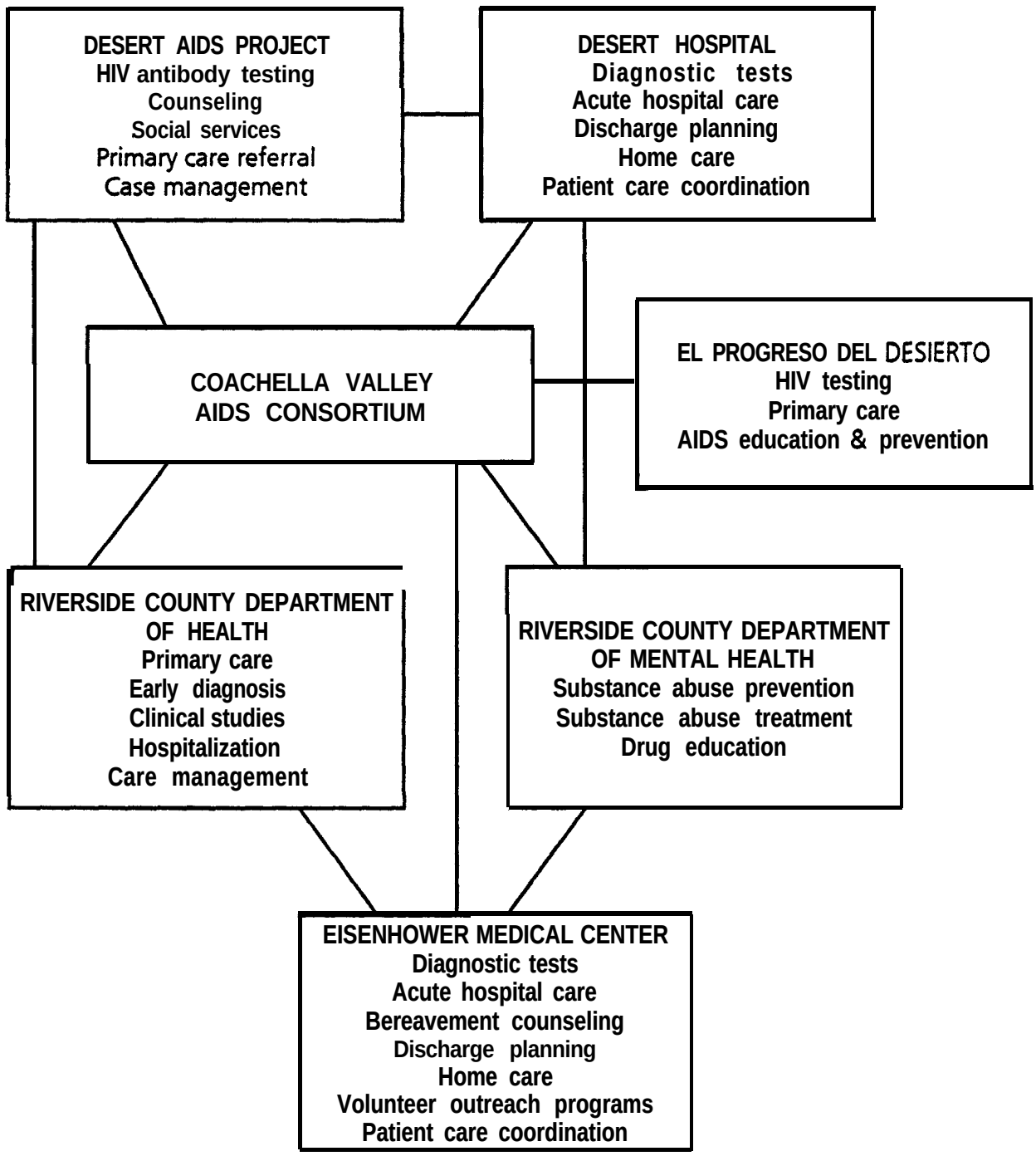


Exhibit 2

HIV Program Activities and Resources

Services/Programs:

AIDS/Outreach

Fiscal Officer *(5% time)*
Project Coordinator/Director of Community Health Services (10% time)
Health Educator (80% time)
Psychosocial counselor (consultant)
Community Health Worker (100% time)
Clerk Typist (56% time)
Evaluation Study (University of California, Irvine)
Cornerstone Church subcontract for street theatre (included in consultant costs)

Teen Tea tro

Currently funded through state tobacco/smoking education program; proposal pending for expanded teatro (including AIDS education) for next year.

H/V Testing

(fee for service--California Office of AIDS)
One Community Health Worker (25% time)
Three Lab Technicians (5% time)
Van (included in transportation cost)

Coachella Valley AIDS Consortium (CVAC)

El Rogreso Director, Community Health Services (6% time)
El Rogreso Executive Director (3% time)
Desert Hospital (space, legal services)
Eisenhower Hospital-private MD who is AIDS specialist
Desert AIDS Rogram
AZT Program
Social Security
Substance Abuse Task Force
Familias y SIDA
Catholic Charities (providing funding for Spanish-speaking counselor)

Exhibit 2 (continued)

Coachella resources-total AIDS Program:

Director of Community Health Services (30% time)
Health Educator (85% time: 70% AIDS education, 10% HIV testing, 5% case management)
Community Health Worker (10% HIV testing, 90% AIDS education)
Executive Director (5% on CVAC)
Lab Technician (5% time)

Resources Not Quantified:

Eligibility worker (trained/provided by Social Security)
Legal services to patients (provided *pro bono* through Catholic Charities)
Resources of CVAC (provided by other coalition members and grant to CVAC)

Exhibit 3

El Progreso del Desierto, Inc.
HIV Program Integrated Services Costs

RESOURCE CATEGORY	E l - Proqreso	U.C. Irvine	Catholic Charities	Ryan White	TOTAL
Personnel (1)					
Dir. Community Hlth Svc(2)	$ 8,726	$ 1,780			$10,506
Health Educator (3)	$ 24,225				$ 24,225
Community Hlth Wkr (4)	$ 14,235				$ 14,235
Community Hlth Nurse (5)	$ 3,500				$ 3,500
Lab Technician (6)	$791				$ 791
Executive Director (7)	$ 3,000				$ 3,000
Fiscal Officer (8)	$ 1,800				$ 1,800
Clerk Typist (9)	$ 5,700				$ 5,700
Subtotal	$58,477	$ 1,780			$ 60.257
Fringe (23%)	$ 13,450	$ 409			$ 13,859
TOTAL PERSONNEL	$ 71,927	$ 2,189	SO	SO	$ 74.116
OTHER DIRECT (10)					
PC Rental	$ 1,000				$ 1,000
Rent	$ 3,000				$ 3,000
Office Supplies	$ 500				$ 500
Health Ed Mat'ls	$ 1,000	$ 200			$ 1.200
Duplicating Mat'ls	$ 800				$ 800
Staff Development	$ 500				$ 500
Meeting Expenses		$ 161			$ 161
Consultants (11)	$ 1,950		$ 6.000		$7,950
Interviewers		$ 2,400			$ 2,400
Lab Fees (12)	$ 2,650				$ 2,650
Lab Supplies (13)	$ 200				$ 200
Travel	$ 800				$800
Telephone	$ 250	$ 50			$ 300
Postage	$150				$ 150
Utilities	$ 364				$ 364
Housing				$ 9,000	$ 9,000
Food				$ 2,000	$ 2,000
Psychosocial Counseling				$ 15.000	$ 15,000
Case Management				$ 13,000	$ 13,000
TOTAL	$ 85,091	$ 5,000	$ 6,000	$ 39.000	$ 135,091

.) Based on salaries for FY ending June 30, 1991.
(2) Assumes 30% time on HIV programs, partially reimbursed by U C Irvine for participation in evaluation study.
(3) Assumes 70% time on AIDS education, 10% on HIV testing, and 5% on base management.
(4) 1 FTE.
(5) Assumes 10% time on HIV programs.
(6) Assumes 5% time on HIV testing program.
(7) Assumes 5% time for participation in CVAC and coalition building.
(8) Assumes 5% time on HIV programs for fiscal and contract management.
(9) Assume8 50% time.
(10) Unless otherwise specified, direct costs are those itemized in AIDS Education contract budget for FY ending June 30, 1991.
(11) Catholic Charities provided $6,000 for six months to Familias y SIDA for a Spanish-speaking counselor.
(12) Contract costs for HIV tests are $12.50 per test; 212 tests were performed in FY ending June 30, 1991.
(13) Estimate by Chief Financial Officer to cover materials for drawing blood samples.

Illinois Migrant Council
Chicago, Illinois

Summary

The Illinois Migrant Council (IMC) is an organization whose primary funding originates from the Department of Labor, 402 Migrant Program. IMC also receives a grant from the Public Health Service to provide health care to migrant and seasonal farmworkers on a state-wide basis. IMC receives PHS 329 funds only and is in full operation on a seasonal basis. Although IMC has been referred to for many years as a "voucher program," it is much better described as a nursing and outreach model. Case management of each patient is a practice which IMC has employed for many years as an effective means of accessing care for a population base which is not large enough to support the more traditional "medical model." Thus, the very design of IMC's health program is founded, in part by necessity, upon the concept of interagency coordination of services. This evaluation will focus on the overall interagency effort, since it is such an intrinsic part of the total operation and is unique among migrant health centers.

Background

The characteristics of the IMC service area are similar to those of many upstream migrant areas in that the project covers a wide geographic area with a service population spread throughout the state. Compounded by the seasonal demand for care, this diffusion presents unique challenges to any organization operating a health delivery system. The solutions of the more traditional medical model are inappropriate in this instance; however, the responsibility to provide comprehensive care remains. The use of vouchers is an important means of referral to private practitioners. However, the individualization of care and follow-up actually provides greater continuity than is implied by the term "voucher."

In essence, IMC has risen to the challenges presented by the geographic diffusion of its user population by assuming the responsibility for coordinating care and utilizing local resources. The actual arrangements vary from service area to service area depending upon the resources available in each local community. A great deal of effort is required to maintain on-going communication and a positive relationship with so many different entities, especially when resources are scarce. These arrangementshold the key to stretching limited dollars to serve a maximum number of patients, and interagency coordination is perhaps the only solution to adequately meeting the needs of this population.

Organization and Staffing

The migrant health program is one component of the entire IMC operation, which is directed by the agency's Executive Director. The Director of Health is primarily responsible for administration of the program, while the the Clinical Director oversees

all aspects of the organization and implementation of clinical activities, including nursing policies and protocols, pharmaceutical agreements, interaction with the Health Departments, participation in the Migrant Clinicians Network, and on-going contact with seasonal nursing staff. The Health Resources Coordinator is responsible for development and monitoring of special projects, such as the dental services, and for on-going supervision of all of the interagency agreements.

Coordination and Integration of Services

Because of the distinct communities surrounding each service delivery site, the available resources differ from site to site. Several are available on a statewide basis. This report will: 1) describe the services which are agency-wide and common to most sites; 2) explore, on a site-by-site basis, each package of interagency services available; and 3) explore more fully the Woodstock site and two interagency relationships which are of particular interest to this evaluation project (the McHenry County Health Department and a private practitioner who sees migrant patients in his office under a contractual agreement with IMC).

Agency-Wide Coordination and/or Integration

The following entities coordinate universally with IMC in all of their service areas. A brief description of each joint effort will explore the extent of integration of services:

County Health Departments
IMC Intra-Agency Activities
Department of Rehabilitation Services (DORS)
Department of Public Aid
Migrant Education
Migrant Head Start
State Department of Health
Inter-Agency Committee on Migrant Affairs (IACOMA)
American Medical Students Association (AMSA)
Rural Community Assistance Program (RCAP)

- County Health Departments (formal and informal agreements)-All county health departments work directly with the IMC staff in areas where farmworkers are served. Services provided at no cost to IMC include the Women, Infants and Children program (WIC), immunization, family planning, prenatal services, control of parasitic infections, treatment of sexually transmitted diseases, and dental care where available. In this relationship, the IMC staff do the initial patient workup and risk assessment and refer the patient to the health department for the actual delivery of care. IMC staff provide outreach and translation services to the patient as a part of the referral. Of particular interest is the comprehensiveness and continuity which is achieved on behalf of prenatal patients: The same physician who provides prenatal

services also performs the delivery, an arrangement which is very difficult to coordinate, especially given limited resources.

Although these relationships work better in some Illinois counties than in others, the fact that they work well is a tribute to both IMC and the health departments. In many areas of the country such relationships either do not exist or suffer from territorial, logistical and prejudicial barriers. Some counties simply do not see that they might have a responsibility for farmworkers because they see that as the job of the migrant health center, and as such, a job they do not have to worry about. Such an attitude is fostered by the shortage of local resources in many areas, the seasonality of farmworkers' presence in upstream areas, and the lack of bilingual staff and evening hours. Geographic location is also another problem. That these barriers can be overcome is proven by the experience of IMC. The pooling of resources between agencies has clearly leveraged services on behalf of farmworkers which would not be available otherwise.

- IMC Intra-Agency Activities (informal arrangements)—One model of unique integration is the intra-agency relationship between the health program and the labor program within IMC. Major benefits of this relationship include the achievement of one-stop shopping for many services for shared clientele, joint recruitment and outreach, referrals for job training, and provision of education programs such as English as a Second Language and Adult Basic Education, and housing for families committed to settling out of the migrant stream. Emergency food is provided on a limited basis, as is emergency housing. Joint staffing and housing of the programs in accessible locations is pivotal in the design of this relationship.

- Department of Rehabilitation Services (formal written agreements)—IMC's strong relationship with DORS also has a significant impact upon the operation of the health program through its coverage for services to rehabilitate workers, including hernia treatment and surgery, diseases and injuries of the eye, prosthetic replacement of lost limbs, intervention on coronary cases, and other problems which interfere with a worker's ability to be gainfully employed. DORS is very adequately staffed with bilingual counselors, and staff from both agencies work together to provide in-camp outreach services. Again, this is a relationship which in some states is virtually nonexistent, with farmworkers seen as an unfortunate burden on an already overloaded system. Illinois is to be commended for the full extent of its provision of services to all who live in the state.

- Department of Public Aid (formal written agreements)-A strong relationship exists between IMC and the Illinois Department of Public Aid for food stamps and Medicaid application processing. Under a contractual agreement, IMC staff are certified by Public Aid as food stamp eligibility workers, and IMC is reimbursed for the salary and benefits of these workers. The process of

determining eligibility and expediting actual issuance of food stamps is well established.

Presumptive eligibility is in place for prenatal care; however, Medicaid eligibility is difficult to achieve and sustain for this population. Significant problems exist, such as the fact that the application process for Medicaid requires two tips to the Public Aid office, and the state requirement that once they qualify, farmworkers reapply every month to verify continued financial eligibility. Neither federal nor state policy allows for income averaging to balance out the highly seasonal nature of farm labor income. These policies interrupt the farmworker's earning ability and limit participation in Medicaid to preseason arrival months and when serious health problems require tertiary care. Patients who have applied for amnesty under IRCA simply don't qualify for Medicaid, and are enjoined from such participation. IMC, like many other migrant health centers, is not able to stretch their operating budget with Medicaid reimbursement.

- Migrant Education and Head Start (formal agreement)—Written agreements are in place which facilitate highly functional relationships with each of the local Migrant Education and Head Start programs. Integrated services include performance of physical exams through IMC, with reimbursement by the education program for approximately 50 percent of the cost. This allows for early identification and intervention of health problems. The education programs involve parents by requesting them to participate in all health appointments, if possible, 'and obtaining informed consent for immunizations. The Head Start program, in particular, effects active parental involvement through the strength of its Parent Council and Parent Fair. These relationships require that local and state-wide staff get together and, through use of a planning grid, identify key issues for each season. Mental health, nutrition and dental assessments are provided by different members of the integrated team and serve as the basis for prioritizing individual care throughout the season.

  Dental caries represent a significant problem among all farmworkers. The integration of efforts to provide dental services for children enrolled in Migrant Education and Head Start programs is highly successful, including on-site (school) core, use of mobile units, preventive education and prophylaxis, and treatment upon referral. A fixed rate of $20.00 is paid to IMC for each Head Start child seen. There is no charge for children under two years of age. A contractual agreement with the Migrant Education program provides $15,000 to IMC to care for 1,200 school-aged children's dental needs. This agreement has allowed IMC to provide services to all students, regardless of the differences between PHS 329 and Department of Education definitions of eligibility. Prioritization of care is based upon an assessment of need, not status. The dental team coordinates a state-wide effort to identify and treat dental priorities, particularly among children. Emphasis is placed on the provision of preventive services, including hygiene, fluorides and sealants. The team is comprised of one senior and one junior operative and two hygienists. This

program is staffed in part by Loyola University of Maywood, Illinois. County health departments, Migrant Education, Migrant Head Start, and private dentists are all partners in this effort, which operates 5-6 sites each season.

In order to assist the Head Start program in meeting their HHS requirements, IMC nursing staff visits each school once per month during the season to consult with staff and provide health education training. Other features of the integration of care includes joint staffing at school sites, record sharing throughout the season, and an end of year "record swap" to make sure that all documentation is complete in each child's record.

- State Health Department (informal agreements)-An exemplary working relationship has evolved over the years, with IMC staff serving on key committees within the state health department and the health department participating as a full member of the Inter-Agency Committee *on* Migrant Health. This joint participation and coordination in structured settings has engendered a tight communications link end seems to have even created a "pro-migrant" atmosphere within the health department. Specific issues which IMC and the state health department address on an integrated basis are identification and reporting of housing, field sanitation and pesticide use violations. The health department responds quickly to these reports and pursues resolution on a timely basis.

- Inter-Agency Committee on Migrant Affairs (formal leadership arrangements)—IMC has taken a leadership role in the on-going activities of this state-wide interagency committee. They meet on a state-wide basis six to eight times per year. Local area participants are encouraged to get together once a month during the season. The Committee holds an annual conference, in a retreat setting, for training and orientation purposes. The Conference of Churches and the Migrant Ministry are also involved in this effort, along with the state and federally-funded migrant service organizations, with major effort put forth by the state Department of Labor. Issues covered on the agenda include developing priorities, identifying a primary focus for joint effort for each year's meeting, trend analysis, performance of state-wide profile, H2A application, joint efforts at legislative briefing, identification of gaps in state services, and use of the Farmworker Objectives for Year 2000. Participation in the activities of this coalition requires an investment of time and money. The IMC Executive Director is very supportive and assists with other dollar resources to assure that farmworkers and staff are able to participate as leaders and presenters in this coalition.

- American Medical Students Association (formal written agreements)—Additional overall efforts include on-going participation in AMSA's intern placement program. Achievements of current and former interns include provision of technical assistance to growers at the labor camps with state health department officials on issues of field sanitation and resolution of problem areas. A state-wide directory of labor camps developed by an intern has become an

invaluable database. Interns have also focused on the development of environmental programs, and of migrant-specific information to assist in legislative briefings. Supervision of AMSA interns has been the responsibility of IMC health program staff, another non-traditional expense.

- Rural Community Assistance Program (formal written agreements)-Through funding and technical assistance from RCAP, IMC is able to conduct environmental projects, including a recent field sanitation survey, identification of 'hot spots," organization of data by type of farming operation, and reporting of problems to the state health department inspectors for follow up.

Site-Specific Coordinations

IMC provides health care in the following areas, which will be discussed on an individual basis:

Chicago Heights/Cook and Will Counties
Momence/Kankakee County
Onarga/Iroquois county
Aurora/Kane County
Hoopeston/Vermillion County
Princeville/Peoria County
Cairo/Pulaski county
Woodstock/McHenry County

Because of their similarity, the Chicago Heights, Momence, and Onarga service areas will be discussed as one.

Service Area	Types of Interagency Integration
Chicago Heights, Momence and Onarga	
1,150 users/l,800 encounters	Aunt Martha's, a residential prenatal and delivery program for young women up to 25 years of age Families with a Future, funded by the State Health Department, provides pharmaceuticals, family planning, pregnancy testing, counseling, and pap smears in a home-style atmosphere which is comfortable and attractive to farmworkers. This program (Kankakee County only) operates as a part of a larger network of service delivery entities, IMC is funded $30,000 each year to provide case management for farmworkers who participate in the full

network of services. This is an example of where case management absolutely works on behalf of the patient and with the full cooperation of all parts of the network.

Access to Care, in its first year of implementation, accepts referrals from IMC for farmworkers. Eligibility determination is performed on-site at the IMC office, and patients can be referred for immediate care. Services include pharmacy, x-ray, lab, and referrals to specialists at the minimum fee. This program is operated by a local private, non-profit organization as a pre-paid program for provision of primary care services. This program is available to farmworkers in only two townships and serves only those who cannot qualify for public aid.

Wellness on Wheels, providing mostly screening, Cook County Health Department preventive services. Services are available for adults only and include both medical and dental and evening clinics.

Aurora:

600 users/1,300 encounters

Mental health (local, 3 counties) plus transportation

The Visiting Nurses Association (VNA) provides a comprehensive set of services to farmworkers who are initially assessed by IMC and referred to the VNA. This has been a long standing relationship as a result of the VNA being very well established in this particular area. Services available to IMC patients include family practice family planning, immunizations and WIC.

The Health Department has only been in this area for five years and offers limited services only.

A private nursing group provides im-

munizations to farmworkers (at $4.00 a shot).

A grower-established day care center in cooperation with Child and Family Services.

Hoopeston:

650 users/1500 encounters

IMC operates a full clinical facility at this site, with in-house clinics staffed by contract physicians. Evening clinics are held 2-3 times per week during the season. This is a very small community, essentially a cannery town. The system here works very well and is highly efficient. The primary coordination effort which is unique to this area is the coordination of care with the community health center for corn de-tassellers;

Princeville:

Services in this area are provided under a fee-for-service contract in what was originally an IMC site which expanded to an RHI. The efforts of this operation were sustained primarily by one individual. After the demise of that individual the practice was bought up by a for profit group. IMC has had a good working relationship with this entity, a for profit subsidiary of the Methodist Hospital. IMC hires and places an outreach worker in the clinic. This person, a migrating farmworker has been with IMC for 20 years, but has recently decided not to migrate any longer. This model really worked well, and is now experiencing some problems.

Cairo:

700 users/700 encounters

Services are provided on the site of an in-transit Rest Center for farmworkers. The IMC 402 program puts some funds into emergency food and shelter. IMC staffs this site with nursing personnel on a 3:00 p.m. to 11:00 p.m. schedule to provide services to families as they come into the area toward the end of the day. Ser-

vices include health assessments, episodic care and referral to health centers at the point of destination of the migrating families.

Woodstock:

560 users/1500 encounters

The Mc Henry County Mental Health Program provides funding to IMC to provide employment of an Early Child and Adolescent Case Manager (IMC site) This program pays for outpatient referral services for a maximum caseload of seven patients and provides comprehensive counseling to family members as well. Prior to this arrangement referrals were made to Child and Family Services, to a clinic with a huge waiting list and virtually nothing could be done to assist farmworkers. Current arrangements include weekly case management meetings, and substance abuse intervention strategies. Contacts as a result of this relationship have also facilitated provision of mental health services to adults, but there is a great need for more. The Mental health program needs more Hispanic providers, and staff would like to see all agencies work together in order to achieve true one stop shopping for family mental health services.

Contractual physician services provided at the physician's office.

Exceptionally strong working relationship with the County Health Department.

Relationship with McHenry County Health Department

Description

The majority of migrant and seasonal farmworkers are in McHenry county; other counties have only a small pocket of seasonal workers who obtain care in McHenry county. Re-season brainstorming sessions are held each year in order to set joint priorities for the season. A joint team of IMC and county health department staff

canvass 100 percent of the migrant camps at least every other year, providing comprehensive assessments of all farmworkers in the area. The health department and IMC approach this as **a team: The** heath department provides a bilingual nurse and IMC a provides nurse and bilingual community health worker. This works because all staff are willing to work, even at night. This program was created from the bottom up, not from the top down, and thus has the support of the front-line workers (as compared to the situation in another county where resentment exists on the part of health department staff).

Clinics are held twice per month during the season, and include diagnosis and treatment of problems identified. The health department bears the cost of the expenses related to holding the clinics (providers, medications, facility), while IMC coordinates outreach, transportation, and registration of participating patients. One priority is the administration of tetanus immunizations for adults on a county-wide basis. Since this requires two shots in year one and one shot in year two, this represents a significant effort. Fortunately, this is all that is required to keep the patient current for the next ten years. It took three years to get approval from the McHenry county administration to administer shots at remote site; the program uses informed consent forms assiduously.

The McHenry County Health Department staff all agreed that this is a highly functional relationship. Staff explained the origins of the collaboration effort, how it currently works (i.e., immunizations, adult treatment, sexually transmitted disease components, WIC, wellness, etc.), and the staffs personal commitment to all farmworkers served. Health department staff spoke eloquently about the rewarding nature of working with farmworkers, and added, 'It's fun."

Impact/Benefits

The partnership between IMC end the McHenry County Health Department yields a number of benefits from the perspectives of clinic users, IMC itself, and the health department. Patients receive improved access to care, better continuity of care, availability of a more comprehensive set of services, personalized guidance through what might otherwise be a maze of providers, and assurance that the care provided will be relevant to their linguistic and occupational needs.

For the health center, this relationship eliminates the professional territoriality which frequently characterizes similar relationships and provides a great deal of satisfaction to IMC's professional team, offering rewarding professional opportunities to IMC staff and reducing the frustration factor which occurs in isolation. By working with the health department, IMC is able to leverage care far beyond what would otherwise be available and to tap a diverse set of professional skills which would not otherwise be available for a small and isolated population. In addition, the health center can play a lead role in the provision of care without being solely responsible for doing so.

The health department also benefits from the elimination of territoriality and the increased staff satisfaction provided by this relationship. In addition, the department

is able to demonstrate its commitment to serve all patients in the area, without bias regarding residence, occupation or ethnicity. Health department staff find the flexibility to work with farmworkers in a non-traditional service delivery model and to make a difference for this special population very rewarding. Finally, the department receives reinforcement of the significant impact which nursing can have on a population when nurses are allowed the leeway to work in an independent capacity.

Integration of Services with Private Practitioner

Description

Migrant health centers have relied upon long-standing relationships with local community providers as a means of providing physician services to a very seasonal and geographically diffused population. In the mid-1980s, many health centers were criticized for doing so because it was perceived as a less than comprehensive arrangement. IMC has preserved these relationships, out of necessity, as a result of the need to serve very small pockets of farmworkers all over the state. This type of arrangement has its place and can work very well under certain circumstances. One such contract with a local family practitioner provides services to farmworkers from McHenry and Lake counties in the practitioner's private office, with case management services coordinated by IMC staff. Patients are not restricted to counties of residence, but are encouraged to use the physician who is most convenient to their location.

Under this arrangement the patient contacts IMC staff, who screen the patient and authorize care. If any preliminary lab work is called for, IMC nursing staff draws the blood and it is sent out to a private lab. The patients are then instructed to contact the provider's office for an appointment. The patient is issued a voucher for a negotiated price, contingent upon services required, and the pays a $5.00 co-pay fee per voucher to IMC. Limited numbers of lab and X-rays are performed by the provider at a price which is one-fourth that of the local marketplace, with the patient paying a portion of the fee. The voucher is returned by the physician's office to IMC with information regarding services rendered and the diagnosis and treatment. If more immediate follow-up is required, the provider or his staff contact IMC in order to complete the communication. Referrals to local pharmacies are facilitated by issuing limited-cost pharmacy vouchers directly from the private provider.

The interview with the private practitioner, located in Harvard, Illinois, reflected a healthy respect on his part for the role of IMC and an appreciation for the quality of communications and follow-up related to individual patient care. He indicated that the system is working well, and that he is pleased to be able to devote a small part of his practice to serve farmworkers. He also indicated that part of the reason that he was glad to work farmworkers into his established office schedule is because of the way that IMC facilitates the reimbursement for their care. He is able to do so at reduced rate because of the absence of paperwork. When asked to share his long-range vision for better care for farmworkers, this provider indicated a strong need for greater

education of patients on health issues in order to establish self-reliance and independence, and a desperate need for more funds for lab, X-ray, specialty referral, and hospitalization.

Impact/Benefits

Through IMC's relationship with a local private practice, the population of farmworker patients who are too diffuse to warrant establishment of a clinic operation have access to physician care. The relationship offers improved access to comprehensive health services which are located nearby and are not limited to attending special migrant clinics operating a few evenings per week In this way, farmworkers have the opportunity to access care as equals in the community mainstream, and to exercise responsibility for their own individual care (i.e., call for appointment, go on own if able, etc.) while still being assured of the case management process. This relationship assures continuity of quality health care for workers in its service area.

Since the relationship allows IMC to provide care using local resources, there is no need to import health professionals solely to care for farmworkers. By implementing a functional relationship, the health center has sensitized a private provider to migrant health issues. In addition, the relationship allows IMC to contain costs through a negotiated fee structure and to assure continuity and comprehensive care by a credentialed professional for its patients. In addition, IMC staff are afforded the satisfaction related to a successful working relationship within the private sector.

The private practitioner in this relationship is given the ability to make a contribution to a working indigent population, and to incorporate social responsibility into his daily life rather than segregating it. He is also able to accomplish this while being freed from the maze of paperwork which usually plagues those who provide care to the indigent.

Summary

This is an excellent example of a complex network of arrangements which are tailored to the individual needs and demands of each service area. There is nothing static about this network, and it is clear that part of the reason it works so well is the core competencies inherent in the small team of year-round and seasonal staff of IMC. The economy of scale which is achievable in this project would be lost if it were not run as a state-wide whole.

Impact/Benefits

The very clear and primary benefit of this overall joint sharing of resources is the large increase in the total volume of services which simply would not be available through federal dollars alone. The big winner in these arrangements is the patient, who otherwise would not have access to care. Other winners in this configuration are IMC

and its partners, local service organizations, private practitioners, and the communities as a whole.

Costs/Financial Savings

Exhibit 1 shows the total costs of the Illinois Migrant Council services, and their allocation to each of the program's regional nursing centers. Total resource costs of the Illinois Migrant Council include the direct costs incurred by IMC and the estimated value of in-kind services received by each regional nursing center. Where identifiable, direct costs are included in each regional nursing center's resources cost determination. Direct costs are primarily salaries and wages. IMC's total medical costs were allocated to each regional nursing center primarily on the basis of number of users. In certain cases, this method could not be used for Princeville, since it generally operates as a contract clinic. Exhibit 2 provides additional detail on the value of in-kind services as estimated by each regional nursing center. For the three regional nursing centers that were able to provide complete information on total costs and estimates of in-kind services (Woodstock, Aurora, and Chicago Heights/Momence), in-kind services accounted for 15 percent, 54 percent, and 47 percent of total costs, respectively. This provides an indication of the success of IMC's model of service coordination in leveraging resources for migrant farmworkers.

Lessons for Other Migrant Health Centers

There is always a temptation when resources are adequate to try to provide care in isolation from other resources. Necessity has clearly been the mother of invention in this instance, and the creative sets of resources which are employed on behalf of farmworkers could not be mobilized by any one agency alone. There are indications that it was never the intent of Congress that PHS 329 funds would be the be-all and end-all for migrant farmworkers, however in many areas, the general sense is that care of farmworkers is the sole responsibility of the Migrant Health Center because they are paid to do so. It appears that the best grounds upon which to challenge that assumption is on the basis of need. Question: Is it better for a migrant health center to try to provide comprehensive care to a small percentage of farmworkers, or to use the limited federal funds to augment local funds and reach a greater percentage of the total population?

The needs of farmworkers do not always necessitate the services of a physician, often thought to be the ideal provision of care. In fact, limited awareness on the part of farmworkers of simple early intervention techniques emphasizes the need for paraprofessionals and mid-level practitioners in the ideal delivery model. Sometimes service delivery systems get so hung up on a system's needing to be physician-driven and reflect a "critical mass" of providers that they are not sufficiently responsive to the needs of hard-to-reach populations. The experiences of IMC demon&rate that "non-traditional" does not necessarily mean "second class."

Exhibit 1

Illinois Migrant Council
Allocation of Costs to Centers

Resource Category	Notes	Hoopeston	Woodstock	Aurora	Chicago Heights/ Momence	Princeville	Total	Percent
Salaries/Wages								
Clinical	(1)	$ 22,656	$ 42,892	$ 19,328	$ 31,210	$ 9,741	$ 125,827	.201
Admin		$ 21,523	$ 18,997	$ 18,716	$ 27,325	$ 7,018	$ 93,579	.149
Admin-Dental		$ 3,714	$ 13,801	$ 7,054	$ 5,623	$ 3,884	$ 34,076	.054
Total Salaries/Wages		$ 47,893	$ 75,690	$ 45.098	$ 64,158	$ 20,643	$ 253,482	.404
Fringe Benefits	(3)	$ 13,123	$ 20,739	$ 12,357	$ 17,579	$ 5,656	$ 69,454	,111
Indirect Costs	(3)	$ 12,548	$ 19,831	$ 11.816	$ 16,809	$ 5,408	$ 66,412	.106
Other Direct								
Rent	(1)	$ 6,156	$ 2,220	$ 2,820	$ 2,148		$13,344	.021
Utilities	(4,d3)	$ 2,420	$ 2.060	$ 2,160	$ 3,360		$ 10,000	.016
Supplies	(1)	$ 363	1'309	$ 324	$ 504		$ 1,500	.002
NARN	(1,6)	$ 1,210	$ 1.030	$1,080	$ 1,680		$ 5:00o	.008
Contractual								
NARN	(4,d2)	$ 4,369	$ 3,719	$ 3.900	$ 6,067		$ 18,055	.029
Ancillary								
Medical	(4,d2)	$ 19,360	$16,580	$ 17,280	$ 26,880		$ 80,000	.128
Lab	(4,d2)	11.936	$1,648	$ 1,728	$ 2,688		$ 8,000	.013
X-Ray	(4,d2)	$ 484	$412	$ 432	$672		$ 2,000	.003
Pharmacy	(4,d2)	$ 3,872	$ 3,296	$ 3,456	$ 5,376		$ 16,000	.026
Other		$ 726	$ 618	$ 648	$ 1,008		$ 3,000	.005
Med. Phys						$ 17,600	$ 17,600	.028
Lab, etc.						$ 2,400	$ 2.400	.004
Medical Director						$ 1,500	$ 1.500	.002
Dental	(4,d4)	$ 3,137	$ 11,654	$ 5,967	$ 4,742		$25,500	.041
Travel	(4,d1)	$ 1,495	$ 1,320	$ 1.300	$ 1,898			.010
Misc. Fees	(4,d1)	$ 1,840	$ 1,624	$ 1,600	$ 2.336,	$ $487 600	$$6,500 8,000	.013
Health Services								
NARN	(4,d2)	$ 3,267	$ 2,781	$ 2.916	$ 4,536		$ 13,500	.022
NARN Travel	(4,d2)	$ 1,384	$ 1,178	$ 1.236	$ 1,922		$ 5,720	.009
TOTAL IMC		$ 125,583	$ 166.609	S116.117	$ 164,364	$ 54,295	$ 626,967	1.000
In-Kind (Others)	(2)	$ 6,471	$ 30,323	$ 139.080	$ 146,044	(5)	$ 321,918	
Total		$ 132,054	$ 196.932	$255.197	$ 310.408	$ 54.295	$ 948.885	

1) Actual costs incurred per adjusted 329/330 grant award.

2) Estimated value of services prepared by regional nursing coordinators are used in this evaluation. These estimates are considered to have a higher degree of accuracy than budgeted grant amounts. This higher degree of accuracy in supposed upon the regional nursing coordinator being nearer to service delivery than the budgeting process.

(3) Fringe benefit rata used is 2'7.4%. Indirect rata wed is 26.2%.

(4) Percentages used to allocate costs to centers (d1=medical users with Princeville, d2=medical users without Princeville, d3=dental users with Princeville, d4=dental users without Princeville).

(5) No value available for Princeville.

(6) NARN=Nursing Assessment and Referral Network

Exhibit 2

Illinois Migrant Council
Value of In-Kind Services

	Hoopeston	Woodstock	Aurora	Chicago Heights/ Momence	Total (Actual)
DCFS					
Head Start Physicals	$ 1.459		$ 32a	$ 399	$ 2,178
Head Start Dental				$ 610	$ 610
IL Deot. of Education					
Dental Care				$ 660	$ 660
Local Health Depts.					
TB X-Rays	$ 225				$ 225
Access to Care				$ 435	$ 435
Immunizations-Adult		$ 1,360			$ 1,360
Anemia Screening		$ 256			$ 256
Prenatal	$ 850	$ 1,300	$ 31,500	$ 5,195	
Well Child		$ 2,412	$ 1,000	$ .7,255	$ $38,845 10,667
Wellness on Wheels				$ 5,580	$ 5,580
Family Planning	$601		$ 1,750		$ 4,515
WIC	(1)	$ 2,900	$ 2,975	$ 2,886	$ 8,705
DORS	$ 1,727			$ 3,500	$ 1,727
Dept. Crippled Children	$ 2,150				$ 5,650
Eyeglasses	(1)	$ 3,475	$ 3,475	$ 2,525	$ 7,535
Misc. Health Dept.		$ 450			$ 450
Deot. Public Aid	(1)	$ 18,170	$ 100,000	$ 114,350	s 232,520
TOTAL	$ 6,471	$ 30,323	$ 139,080	$ 146.044	$ 321.918

(1) Unable to estimate

Keystone Migrant Health
Chambersburg, Pennsylvania

Summary

Keystone Migrant Health is a relatively new organization which has been funded to provide primary health services since 1987. It was formed in response to an urgent need for a locally-based organization to assure continuity of services during the transition from one statewide PHS 329 grantee to another. Keystone is a small organization, serving two counties and 1,000 annual medical users. It operates under a contract with Pennsylvania Rural Opportunities, Inc. (PRO). The season for this area is short and intense, fourteen weeks in duration. A steady increase in the number of farmworkers served has occurred each year, with concurrent steady growth of the number in the area due to changes in the agricultural pattern.

The program is unique because of several key players in the service delivery system. They include a local physician who essentially volunteers his time; his partners, whose time is sometimes volunteered for them; and a very special Program Director who donates 100 percent of her salary back to the corporation in order to expand direct services to farmworkers. Keystone was incorporated in 1985.

The altruism reflected in the origins of Keystone by no means reflects an expansive willingness on the part of the community to embrace the needs of the farmworker population. Rather, it is indicative of the commitment of a few individuals to serve this population, and to educate their colleagues and neighbors to the realities of farmworkers. All of the popular myths about farmworkers prevailed in this community, as they do in most areas of the country which are inundated with a seasonal influx of "outsiders" who are different in ethnicity, culture, language and occupation from the area residents.

Like the Illinois Migrant Council, which was also included in this study, the need to leverage a maximum of resources on behalf of farmworkers necessitated a program design which stresses interagency coordination. In the case of Illinois, the majority of resources leveraged are state and local community public service organizations. At Keystone, however, an army of private practitioners, their office staff, and in some cases their spouses has been mobilized to serve farmworkers.

Background

Agriculture in the catchment area for Keystone is largely dominated by orchard crops, including peaches, apples, and nectarines. The season lasts from the third week in July through mid-November. The clinic's user population is predominantly Hispanic, Mexican, Puerto Rican, and Haitian, with homebases in Florida, the Carolinas, and Georgia.

Organization and Staffing

Keystone Migrant Health operates out of one main office/clinic facility which houses the administrative offices and serves as a base for the outreach nurses' field activities. This facility also includes several examination rooms and a waiting room which are used for regularly scheduled clinics during the season. Staffing includes a physician's assistant, registered nurses, a nurse practitioner, and a community health worker. In addition, the private practice facilities of two local providers are used for medical and dental patients, respectively. Patients are seen on an individual referral basis in those offices during the day, and the providers offer the use of their facilities for evening clinics from 6-11:00 during the season. Great emphasis is placed upon provision of nursing outreach services as an effective means of assuring early intervention for this hard-to-reach population. Each patient's care is managed on a case-by-case basis to assure that referrals are completed and that the patient follows through on the recommended treatment regimen.

Coordinated Dental Program

Description

Dental problems have been identified as among the most prevalent health care needs for farmworkers, and yet the focus of the migrant and community health center programs is clearly upon medical needs of the target population. Some migrant patients, especially adults, have received little or no dental care in the past. It is not unusual to see a patient who has never had prophylactic treatment. Basic dental cognizance is minimal, and the absence of good dental practices results in serious and neglected oral health problems. It is unique for a program of the relatively small size and young age of Keystone to have accomplished so much with so little.

The patients of Keystone Migrant Health are as in need of access to dental care as any other migrant population. Not funded to provide dental care, Keystone searched for a solution to an overwhelming problem. Keystone was able to recruit a local dentist into the solution, and in 1989 began to hold its first dental clinics. In the ensuing three years, what was once a stop-gap solution has turned into a service delivery system which is very appropriate to the size and seasonal nature of the farmworker population in the Chambersburg area.

Essentially, clinics are now pre-scheduled on a season-long basis for a total of 21 blocks of clinic time. The Dental Director volunteers his clinic facility, which is staffed by as many as twelve dentists and their assistants each night. Medical and dental patient records are integrated so that pertinent information on each patient is available to all providers. The evening dental clinics are supplemented with outreach efforts to the schools and day care centers in order to assure that all age groups are served. Referrals and follow-up are handled by Keystone staff, with patients requiring additional dental care scheduled for subsequent clinics.

The interview with Keystone's Dental Director revealed that one of the key elements to the success of this program is that it is organized in a manner which allows the dentists to do just what they are best at: providing dental care. No paperwork, no eligibility requirements, no patient registrations, no billing forms, no management hassles. Just walk into a room, assess the problem, treat the problem, and document in a chart what was done and what remains to be done. Keystone manages all of the rest. The dentists love the program and will do as much as the operatories, space, and time permit. The patients seem to greatly appreciate the spirit of the service. The clinic atmosphere is casual although extremely busy, and all patients will be seen so there is a lot of patience. The attitude and strong family ties of the population also add to the dentists' appreciation of their patients and affirm their sense of ability to make a difference in a big way.

The position of Dental Director demands great responsibility and offers no remuneration. Interestingly enough, the current Director's response to that responsibility has been to widen the net and recruit colleagues from all over the state to participate in this program. A total of 21 volunteer dentists participate in the Keystone dental program each year. The program has been visited by a representative of the state dental association, and discussion is underway to try to transplant this effort to other areas of the state. The Dental Director has also begun to participate in the Migrant Clinicians Network and to share his experiences with other migrant clinicians. The affirmation and sense of contribution that he and his wife, who assists him, receive from this volunteer effort are what keep them involved.

Impact/Benefits

Keystone Migrant Health is able to capitalize upon a wealth of resources which expand the volume and quality of services well beyond what would be possible with only federal dollars. More to the point, dental services are not funded by PHS 329 dollars. The costs of administering this volunteer program are minimal, especially considering the fact that the CEO donates her entire salary to the corporation. The major beneficiary in this arrangement is the patient, who has access to dental care. The community of Chambersburg benefits greatly as a result of the increased awareness and acceptance of farmworkers. Previously existing tensions have been eased and the community is able to act in the role of a beneficiary instead of a critic of this population. The dentists who volunteer their time reap both personal and professional rewards from their participation. A stronger network of dental professionals now exists as a result of this effort, and cross-pollenation between the medical and dental communities is taking place.

Costs/Financial Savings

In calendar year 1990, Keystone's expenses, including non-cash value of donated services, facilities, and supplies, totaled $162,047. Exhibit 1 shows the sources of revenue for 1990. Total revenue and expenses were approximately equal. Note that,

although Keystone is a seasonal clinic seeing mostly migrant and a few seasonal farmworkers, the Section 329 funds represent only 44.4 percent of the operating costs. Contracts from the state and other organizations for special services (e.g., WIC, WIN, STD/HIV, TB, etc.) provided 22.7 percent of the costs, and other grants, contributions, in-kind donations, etc. totaled 33 percent of operating costs.

The reimbursement rate for some of the services contracted from the state, such as WIC or STD/HIV screening and treatment, are less than the costs of providing these services when administrative costs, building occupancy costs, and other overhead are allocated fairly across the programs which Keystone operates. However, the variable or incremental costs of these services are less than the reimbursement rates. The contracts for special services generally provide reimbursement for at least the marginal costs of providing these services. Moreover, the marginal costs of providing the services in some cases are no more than the costs of arranging and facilitating referrals would have been, and such referral would have been without additional compensation. Consequently, as long as Keystone has the capacity to manage these added programs within the present space and administrative staffing constraints, Keystone can expand the continuum of care it directly offers without requiring an increase in Section 329 funds.

Lessons for Other Migrant Health Centers

What makes this endeavor so incredible is the fact that it has actually made farmworkers a *cause celebré* in a community which formerly exhibited classic signs of prejudice and fear of an "alien" population. Practitioners from all over the state now approach Keystone and ask for the privilege of working with this challenging population. There is no doubt that this has been accomplished as a direct result of the ties between the principals of the corporation and the established medical and dental community; it is a classic example of clinical leadership at work.

Equally important is that common thread which runs through each of the nine projects studied in this evaluation: the extremely high level of personal commitment and dedication of the staff and governance of the corporation. The clinic's long-standing presence in the community has facilitated their work, but it is only through great personal sacrifice that so much has been accomplished.

Perhaps the most unique feature of this operation is its overall success in marshalling local resources with which to serve area farmworkers. PHS 329 dollars, roughly $70,000 each year, act as the glue which brings together a wide variety of dollars and volunteer services. This has occurred as a direct result of the efforts and commitment of a few individuals within the community. It is important to note that their commitment is for the long run and is oriented to creating positive change in the overall health status of farmworkers.

One question that always comes to light when assessing the expenditure of migrant health dollars is whether there is more "bang for the buck" in an area which will support a traditional medical model than there is in a more sparsely populated area

such as that of Keystone Migrant Health. This question is critical when one considers the care to each individual farmworker to be the priority, not just those who happen to reside in the highest migrant impact areas. However, when one also takes into consideration the large numbers of farmworkers who simply cannot be reached by the Migrant Health Program due to a shortage of funds, it is important to be sure that the dollars have an impact upon as great a number as possible. An easy deduction might be that dollars should be concentrated in those areas where the cost per user is the lowest, therefore serving greater numbers (such as a combined 329-330 operation, or one in which the migrant population alone is densely enough concentrated for a long season to warrant establishment of a traditional physician based model).

Recommendations

- Acquisition of portable dental equipment to take maximum advantage of available volunteers.
- Federally Qualified Health Center design and certification for the Keystone operation.
- Work on access to Food Stamp and Medical Assistance programs for farmworkers.
- Place nurses on the job site in packing sheds.
- Increase public relations activities.
- State primary care association to initiate interagency-oriented planning for indigent population as a whole, working for sustainability.
- Community-based operation as a foundation for growth. The project has begun to write grants for other organizations, and has written in a migrant component.
- Adopt-a-Car&church organization.

Exhibit 1

Keystone Migrant Health
1990 Revenues

PARO 329 Contract	$72,000
PARO/AIDS Services	5,000
PennFree (substance abuse)	17,715
United Way	7,910
In-kind donations and volunteers (medical and dental)	23,470
WIC contract	4,920
STD/HIV clinic	1,536
NEMA	1,688
State TB program	1,075
Other (contracts/programs)	4,951
Other (cash/non-cash contributions, grants, and supplemental awards)	22,124
TOTAL REVENUES	$162,389

1990 Expenses

Wages, Salaries, Payroll Taxes, and Fringe	$82,738
Medical and Professional:	
Contract Services	11,825
Physician Contract	4,692
Other Patient Care	1,897
	18,414
Other:	
Travel	5,000
Insurance	3.571
Dues and Subscriptions	3,462
Supplies:	
Pharmaceutical	7,500
Non-Medical	3,000
Telephone and Postage	1,428
Costs of Occupancy	11,256
Professional Services (legal, audit, etc.)	2,218
	37,435
Cash Expenses, Total	138,577
Non-Cash Costs (donated value):	
Dentists and Support	11.136
Dental Space	800
Optometric Service	876
Physician Time	2,500
Other Volunteer Time	2,252
Pharmaceuticals	5.000
Miscellaneous	606
	23.470
GRAND TOTAL, CASH AND IN-KIND VALUE	162,047

La Clínica del Cariño
Hood River, Oregon

Summary

La Clínica del Cariño (La Clínica) is a community and migrant health center located in Hood River, Oregon which provides comprehensive primary health care services to migrant and seasonal farmworkers and other medically under-served residents of a two-state, three-county area in the Mid-Columbia region of Oregon and Washington. La Clínica is a fully staffed, year-round ambulatory medical facility.

Background

The service area for La Clínica contains an estimated 26,651 farmworkers, including 17,980 migrant and 8,671 seasonal workers. Migrant and seasonal farmworkers make up 61 percent of the clinic's user population. La Clínica had 3,534 medical users in the first nine months of 1990, and a projected twelve-month user population of 4,400 (a 100 percent increase over the same period the year before). Additionally, the clinic projected a 55 percent increase in on-site encounters for calendar year 1990. Because of this rapid expansion of users and encounters, La Clínica board and staff have had to work extremely hard to expand the facility and increase access.

There are a number of changing characteristics which have a significant effect on the surrounding community:

Increasing numbers of farmworker families are settling out in the Hood River area. Many men who have obtained legal residency through IRCA have brought their wives, children, and extended family members to the area. These farmworkers are having great difficulty finding adequate housing in the communinity. In addition, some growers are telling workers that they won't have housing or jobs next year if they bring their families. Apparently, these growers want to separate families in order to accommodate their preference for providing "single man" housing in the orchards.

Most of the farmworkers and their families who are seen at La Clínica are not eligible for Medicaid or Medicare benefits and do not have any other form of health insurance. Additionally, most of the family members who have recently immigrated are undocumented and thus inelegible to work. These two phenomena are creating an increased burden on La Clinica's resources for providing quality care to the farmworker population. There is a drastic upsurge in the number of farmworkers and other low-income residents who cannot afford health care at standard prices. La Clínica stands alone as the only opportunity for an increasing number of residents to obtain affordable comprehensive health care. Also, because of its highly trained providers, the clinic is asked with increasing frequency to provide specialized health care services (e.g., child abuse exams, high risk obstetrical care procedures) for the community.

Through three weekend mobile dental clinics for low-income children in the La Chnica service area, mobilized through the El Niño Sano program in concert with local area dental professionals and Northwest Medical Teams of Portland, over 650 clinical encounters were provided. These clinics underscored critical dental needs far above previously assumed levels, and highlighted the lack of dental care available to indigent and low income people in the area.

Organization and Staffing

La Chnica is directed by a thirteen-member board. The board currently has two vacancies; six of the current eleven board members are clinic users, including two seasonal farmworkers and two migrant farmworkers. The clinic has a strong organizational structure which uses a "Management Team" approach under the leadership of the Executive Director. The management team includes the Executive Director, Medical Director, Financial Officer, Operations Manager, and Medical Provider Team.

La Clínica is currently staffed with 3.5 FTE physicians and a .8 FTE physician assistant.

Perinatal Service Components

LA Clínica has developed a truly comprehensive perinatal program for its migrant and seasonal farmworker clients. La Clínica's staff, both medical and administrative, provide the leadership for this county-wide initiative. The m-house components include the medical evaluation and supervision of perinatal clients and postpartum follow-up. An essential component of this program is the training and supervision of lay health promoters ("promotoras") through the El Niño Sano program. La Chnica has created a case-managed, comprehensive perinatal service delivery system.

Operations

Hood River County Health Department

Under a written agreement between the Hood River County Health Department and La Clínica, clients receive quick services from the Health Department and medical primary care services from La Clínica. Primary prevention and some early screening services are also provided by the Health Department. Funding for these services comes from Title V, which is passed through to the Hood River County Health Department from the Oregon State Health Division. Though this is far from a "one-stop shopping" approach in terms of location, patient flow seems to work well because of the excellent case management provided by La Chnica and by the promotoras.

Hood River Department of Human Services

Through an informal interagency agreement, La Clínica and the Children's Services Division of the Hood River Department of Human Services have designed an inte-

grated approach to delivering services to abused children. Program components include:

- Joint training of staff regarding child abuse recognition
- Focus of foster parent training on the Hispanic population
- Parent training curriculum
- Medical evaluation of suspected child abuse cases
- Photographic equipment purchased by Human Resources for use by La Clínica
- Child abuse prevention and early identification through the El Niño Sano program
- Increased awareness of the need for culturally relevant investigation and case management

Through parallel agency goals and a mutual focus on problem-solving, La Clínica's staff have engendered a positive working attitude and developed several working relationships with the Department of Human Resources pertaining to child abuse intervention. Despite inadequate resources and a history which includes the State Department of Human Resources' image as a "child-snatcher," which is still very present among the Hispanic population, La Clínica's staff have been instrumental in beginning to break down the barriers of mistrust between its client-population and the state agency. Human Resources staff seem committed to increasing integration between La Clínica and the Department, particularly through El Niño Sano. Discussions are underway with good results regarding the Department of Human Resources underwriting part of the cost for the promotoras.

Helping Hand Against Violence

La Clínica has played a leadership role in coordinating access to family violence shelter services for the farmworker population. As a result of an informal interagency agreement between La Clínica and the community-based project Helping Hand Against Violence, a more culturally sensitive and adequate prevention of shelter services has been developed. These include:

- Increased outreach to migrant and seasonal farmworker women
- Access to shelter and counseling services
- Increase in bilingual volunteers
- Cross-training of promotoras in family violence
- Allocation of $3-4,000 to the El Niño Sano program for direct support
- La Clínica referrals make up 25 percent of the Helping Hand client load

- A lifting of the three-day maximum shelter stay for farmworker women

La Clínica's staff have been instrumental as advocates for increased funding for this community-based agency. There is a flexible exchange of resources and ideas between the two organizations and, though the family violence program is inadequately funded with a 1990 budget of only $20,000, La Chnica staff have been quite successful in leveraging a large portion of those resources in volunteer community efforts on behalf of its client population.

New *Parent Services*

New Parent Services is a program which recruits experienced parents and pairs them with first-time parents. Through the advocacy efforts of La Clínica staff and referrals from La Chnica to the New Parent Services program, seasonal farmworker first-time parents are now teamed with promotoras and other Hispanic volunteers. El Niiio Sano and La Clínica staffs are working to jointly recruit Spanish-speaking volunteers who drive and have time to provide services to this program. El Niño staff train New Parent Services volunteers in Spanish on basic health-related issues. In addition, New Parent Services volunteers are given an overview of La Clínica to increase their understanding of community resources.

Hood River Hospital

The medical staff at La Clínica have hospital privileges at the Hood River Hospital. La Clínica physicians bring migrant sensitivity and a Hispanic focus to hospital services. The hospital provides charity care to farmworkers admitted through La Clínica. The hospital has a commitment to care for the indigent population; its administration realizes that the hospital will receive the patients anyway, and that coordination with La Clínica staff can help to offset the ultimate cost of hospitalization. The hospital sees the La Clínica physicians as full members of its physician team, and the chairman of the Hospital Ethics Committee is a former La Clínica provider. La Chnica provides interpreters and, in general, works to increase sensitivity and cultural awareness within the hospital setting. Currently the hospital is recruiting on OB/GYN physician who will establish a private practice to reflect community demographic characteristics and need. The hospital also hopes to increase linkages between the hospital and La Clínica's billing office. The Hood River community is supportive of family practice physicians dealing with obstetrics, and La Clínica staff have increased skills in surgical obstetrics La Clínica physicians also serve on the Quality Assurance Committee for the Hood River Hospital.

Adult and Family Services

Through an informal cooperative agreement between La Clínica and Adult and Family Services, La Chnica is able to leverage approximately 40 percent of the perinatal care dollars spent in the county. La Chnica staff efforts have increased access to Medicaid for the farmworker population. In addition, they have been successful in shortening the time until payment from Medicare to La Chnica, enhancing the working arrangement with the hospital, and fostering community support and acceptance. Adult and

Family Services attributes the quality of the working relationship to the common goal of the-agencies, the close community connection between the chief executive officers, the effectiveness of La Clínica staff as patient advocates, and La Clinica's good public relations and positive public image.

Oregon Health Sciences University

Through a state perinatal project, the Department of Obstetrics and Gynecology at the Oregon Health Sciences University at the School of Medicine provides a high-risk referral resource to La Clínica. Professors from the university make bi-monthly site visits to La Clínica. They provide lectures to clinic staff which are also open to other health providers in the community, and provide a direct linkage with an academic setting and high-risk tertiary care.

Costs/Financial Savings

Exhibits 1 through 3 present financial information on La Clínica's coordinated efforts. Exhibit 1 shows that the clinic's total support and revenues are about $1.1 million; 44 percent of this amount is allocated to the perinatal program, based upon the number of encounters. The El Niño Sano grant provides an additional $153,000 for support of comprehensive perinatal care. Exhibits 2 and 3 show additional sources of support for the El Niño Sano and Perinatal Programs, respectively. As these exhibits show, many agencies contribute to the provision of these services. La Clínica provides 64 percent of the financial support of the perinatal program, and the El Niño Sano grant provides 61 percent of the support for the activities associated with that program.

Lessons for Other Migrant Health Centers

All staff providers at La Clínica have the responsibility for seeking out and negotiating service integration opportunities. Promoting a positive public image for the corporation and being effective patient advocates are important activities for all employees. Though there are almost no formal written agreements or contracts between La Clínica and other community organizations, high-level integration in the superior service delivery system is created by continuous communication, much interaction, comprehensive case management, general concern for and commitment to the Hood River community by the providers, and a stable and exceptional clinical staff. La Clínica has a high profile in the Hood River community. The staff live in the community and provide strong leadership in a number of areas besides the health care delivery system. There is a high level of trust between the administration and the clinical providers at La Clínica, and the clinic employs a collaborative management approach. There is a high degree of delegation of both authority and responsibility, coupled with a nurturing of leadership within all levels of the clinic staff. La Clínica has made obstetrical case management and comprehensive perinatal care for the farmworker population an organizational priority. Compassionate care and the coordination of services outside of the clinic's direct provision are also organizational priorities.

While programs and services are* highly integrated and community resources have been well leveraged on behalf of the farmworker population, the dollars are not nearly as well integrated. Examples include the New Parent Services program use of promotoras without payment, lack of compensation for court appearances made on behalf of the Department of Human Resources by clinic physicians, and the lack of adequate funding for the level of primary care services provided to clients referred by the Health Department. The clinic is beginning to pick up on opportunities to have other agencies underwrite the cost of the share of services provided through the clinic. This is particularly true in the area of El Niño Sano.

The lack of a formal and/or written interagency agreements exacerbates this issue. La Clínica continues to be primarily funded by federal and state grants, demonstration projects, and other 'soft" dollars. As a result, the corporation is susceptible to outside visions and initiatives. There has been little strategic planning to date, and the corporation functions primarily on an informal long-range strategy. For-profit hospital entities which are positioning themselves in some of the counties served by La Clínica could provide competition for La Clínica's resources in the future. Washington State primary care dollars are not the cap to offset the cost of La Clínica's care for their clients. Quality assurance tracking of data back to the clinic and dollar resources is also inadequate.

Recommendations

- Examine the potential to request technical assistance dollars from the regional Public Health Service office to implement long-range corporate and financial strategic planning.
- Examine mechanisms for physician reimbursement for court time and other community services rendered on behalf of other community-based organizations.
- Examine the potential for using promotoras to manage cases under subcontract with private physicians and with the hospital.
- Examine the potential for job-sharing with the Children's Services Division as a career ladder for La Clínica support staff.
- Create written interagency agreements which detail duties, persons responsible, and financial commitment.

Exhibit1

La Clínica del Cariño
Resources and Expenses

Resource Category	Total	La Clínica del Cariño	El Niño Sano (2)	Perinatal (1)
support				
Public Health Svc grant	$ 766,904	$ 614,860	$ 152,044	$ 270,538
IRCA Reimbursement	$ 66,696	$ 66,696		$ 29,346
Other	$ 16,788	$ 10,783	$ 6,005	$ 4,745
Total Support	$ 850,388	$692,339	$ 158,049	$ 304,629
Other Revenue				
Patient Fees	$ 395,090	$ 395,090		$ 173,840
Investments	$5,414	$ 5,126	$ 288	$ 2,255
Other	$ 16,563	$ 16,563		$ 7,288
Total Other Revenues	$ 417,067	$ 416,779	$288	$ 183,383
Total Support & Revenues	$ 1,267,455	$ 1,109,118	$ 158,337	$488,012
Expenses				
Personnel Services	$ 716,688	$613,801	$ 102,887	$ 270,072
Benefits & Payroll Taxes	$ 147,101	$ 125,283	$ 21,818	$ 55,125
Travel & Transportation	$ 16,788	$ 10,873	$ 5,915	$ 4,784
Equipment	$ 25,256	$ 25,256		$ 11,113
Supplies	$ 79,267	$ 73,303	$ 5,964	$ 32,253
Contractual/Consultant!	$ 43,695	$ 42,479	$ 1,216	$ 18,691
Other	$ 161,132	$ 138,024	$ 23,108	$ 60,731
Interest	$ 1,504	$1,504		
Construction	$ 11,582	$ 11,582		
Total Expenses	$ 1,203,013	$ 1,042,105	$ 160,908	$452,768
Excess of Revenue over Expenses	$ 64,442	$ 67,013	($ 2,571)	$ 35,244

l) Perinatal is estimated based upon encounters as 44% of La Clínica del Cariño operations.
(2) Separate budget and accounting records maintained for El Niiio Sano's grant funding.

Exhibit 2

La Clínica del Cariño
Resources and Expenses

Resource Category	El Niño Sano (1)	la Clínica del Cariño (2)	County Health Dept. (3)	Next Door & Related Units	Dental	OHSU	Total
Support							
Public Health Svc grant	$ 152,044						$ 152,044
IRCA Reimbursement							
Other	$ 6,005						$ 6,005
Total Support	$ 158,049						$ 158,049
Other Revenue							
Patient Fees							
Investments	$288						$ 288
Other							
Total Other Revenues	$ 288						$ 288
Total Support & Revenues	$ 158,337						$ 158,337
Expenses							
Personnel Services	$ 102,887	$ 50,337			$ 23,820	$ 1,640	$ 178,684
Benefits & Payroll Taxe:	$21,818	$ 10,274			$ 5,955	$410	$ 38,457
Travel & Transportatior	$ 5,915				$ 250	$ 250	$ 6,415
Equipment							
Supplies	$ 5,964				$ 3.275	$600	$ 9,839
Contractual/Consultan	$ 1,216			$ 6,000			$ 7,216
Other	$ 23,108						S 23,108
Total	$ 160,908	$ 60,611	$ 0	$ 6,000	$ 33,300	$ 2,900	$ 263,719

(1) Separate budget and accounting records maintained for El Niño Sano's grant running.
(2) Value of La Clínica del Cariño contribution is for outreach effort and administrative and management support.
(3) County health departments rely upon El Niño Sano to operate as a Spanish-speaking resource end contribute very little in-kind or direct financial support.

Exhibit 3

La Clínica del Cariiio
Resources and Expenses

Resource Category	Perinatal (1)	Labor & Deliveries (2)	State Welfare (2)	Total
support				
Public Health Svc grant	$ 270,538			$ 270,538
IRCA Reimbursement	$ 29,346			$ 29,346
Other	$ 4,745			$ 4,745
Total Support	$ 304.629			$ 304,629
Other Revenue				
Patient fees	$ 173,840			$ 173,840
Investments	$ 2,255			$ 2,255
Other	$ 7.288			$ 7,288
Total Other Revenues	$ 183,383			$ 183.383
Total Support & Revenues	$488,012			$ 488,012
Expenses				
Personnel Services	$ 270,072			$ 270,072
Benefits & Payroll Taxes	$ 55,125			$ 55,125
Travel & Transportation	$ 4.784			$ 4,784
Equipment	$ 11,113			$ 11.113
Supplies	$ 32,253			$ 32,253
Contractual/Consultant	$ 18,691	$ 171,600	$ 87,300	$ 277,591
Other	$ 60,731			$ 60,731
Total	$ 452,768	$ 171.600	$ 87,300	$ 711,668

1) Perinatal is estimated based upon encounters as 44% of La Clínica del Cariño operationa.

2) Estimated value of deliveries not provided by state welfare department. Sample of deliveries for one month was 20 deliveries, annualized to 240 less 97 paid by state welfare department. 97 births were supported and classified by state welfare as On-Going OB (65) and Citizen Waiver (42).

Migrant and Rural Community Health Association (MARCHA)
Bangor, Michigan

Summary

MARCHA was originally incorporated in 1972 as Berrien, Cass, Van Buren Health Services (BCV Health Services). As a migrant health center, it has expanded to include community operations in the ensuing years. It operated five sites serving five counties. One of those counties is a WE-only service delivery site (Cass county) and the Benton Harbor site (Berrien county) is a comprehensive community health center which also sees farmworkers. The Eau Claire site (Berrien County) is a seasonally intense clinic which operates as a comprehensive center with full physician coverage. The Holland site operates on a year-round basis (serving Ottawa and a portion of Allegan county), and is primarily a migrant site which also serves area residents. The Holland site provides a comprehensive set of health services and full-time physician and nurse practitioner coverage.

The administrative offices of MARCHA are located in Bangor, Michigan, in conjunction with a jointly funded PHS 329/330 migrant community health center; The 1990 BCRR reflects a total of 6,130 medical and 2,182 dental migrant users.

Background

MARCHA employs a wide range of interagency coordination linkages as a standard means of leveraging service resources on behalf of farmworkers. Each of these is briefly described below. Of greatest interest to this evaluation, however, is a long-standing relationship between the migrant health center located in Bangor and the Migrant Education program's Project NOMAD in Lawrence, approximately 11 miles away. This formal linkage will be the focal point of this report.

The following collaborative efforts are in place agency-wide at MARCHA:

- WIC services (five sites).
- The agency distributes 7,100 food packages per year to migrant farmworkers.
- MARCHA works with the Michigan Department of Social Services, taking a leadership role in coordinating on-going activities of the Interagency Council. The Council covers all five counties in the MARCHA service area.
- The agency receives state funds to participate in the Michigan Migrant Health Consortium. MARCHA is also a participant in the Midwest Migrant health Consortium and the Michigan Primary Care Association.
- Through a state-funded nursing outreach program, MARCHA receives $50,000 for medical/dental van operations.

- The Camp Health Aide Rogram, supported by the state health department and Midwest Migrant Health Information Office, utilizes eight Camp Health Aides in the migrant labor camps.

- MARCHA provides family violence and substance abuse services through the Southwest Orientation Center.

- The agency participates on the Hispanic Council in Kalamazoo.

- Dental services are provided to all eleven schools in the area, serving 2,000 migrant users annually.

Site-specific collaborations include:

- Coordination by the Bangor site with the Van Buren County Health Department for HIV support, immunization, biological tests, and tuberculosis referral and follow-up.

- Renatal, high-risk maternity, and specialty referrals to local resources by the Bangor, Eau Claire, and Holland sites.

- Coordination with local and regional academic resources to place students and residents at Bangor site.

- The Bangor site has received full training and certification for administering the EPSDT program under contract with the state. The Holland site has EPSDT certification for maternal support services, outreach services, nutrition, and modified presumptive eligibility, and the Eau Claire site will offer these services beginning in 1992.

- The Eau Claire site works with Southwest Medical Clinics to provide total physician coverage for seasonal operation of the health center.

- The Eau Claire site also has collaborative relationships with the Berrien County Health Department, Migrant Education, and Migrant Head Start.

- The Holland site works with West Ottawa Migrant Education to provide comprehensive nursing and medical coverage. This site also coordinates with Project Salud, an Office of Minority Health outreach nursing program.

- The Holland site has a close working relationship with Zelenka Nursery, a primary agricultural employer in the area, to conduct tuberculosis screening, chest x-rays, and treatment through area resources.

Project NOMAD Linkage

Description

A formal contractual agreement, initiated by MARCHA in 1983, exists between the two organizations. Within this agreement, MARCHA provides a comprehensive set of health care services to all children enrolled in the summer migrant education program. Services provided at the schools by MARCHA include full-time nursing staff; emergency intervention; maintenance of a "sick room;" physical exams; coordination of communication with parents regarding health issues; obtaining of health histories; maintenance of health records from year-to-year; assessment and documentation of immunization information; administration of immunizations, basic medical supplies and some pharmaceuticals; health education presentations to staff and students; and participation in field trips so that nursing staff are always available. Dental services provided at the school through use of mobile and portable equipment include dental screening, prophylaxis, fluoride treatment, and sealants.

Services provided at the health center include medical and dental care by appropriately trained health professionals, waiving of the minimum fee and pharmaceuticals where available to all farmworkers, access to the WIC Program, nutrition counseling and all other services provided at the health centers.

In return for this comprehensive package of services, Project NOMAD has contracted its total health budget to MARCHA. The actual amount has varied from year to year, depending upon the number of children enrolled in the program and the number of schools in operation. The funding of this contract has been based upon the amount of dollars NOMAD previously spent on the cost of contractual nurse coverage, acquisition of medical supplies, and payment to private physicians for performance of cursory physical examinations of children under the age of five years.

In addition to the funding for this contract, NOMAD also provides one to two full-time clerk/health aides for every nurse placed by MARCHA in a school, support services provided by school outreach workers, transportation to and from the clinic, health room facilities, equipment and telephone service.

History

Previous to the implementation of this contract, there was a somewhat competitive relationship between the organizations, with school nurses insisting on getting 'their" patients on an immediate basis with no triage at the school before students were taken to the clinic by an outreach worker. This impact upon an already congested clinic setting resulted in an on-going sense of conflict. The differences between Migrant Education's definition of a migrant farmworker and that of the PHS329-funded clinic also created an unnecessary schism. Furthermore, both programs had funds for health care for migrant students, and both were charged with the responsibility of making

theirs the "last dollar." This created an even greater sense of conflict between the two organizations, both charged with serving the same population.

Once the contract was put into place and resources co-mingled, both programs were united to one cause and barriers were eliminated. The commitment of Migrant Education funds eliminated the need to differentiate between conflicting definitions. Supervision of nursing staff under protocol or standing orders by health center physicians facilitated treatment of minor problems in the school setting and helped to prioritize more serious problems requiring a physician's attention.

This agreement has served as a prototype for each of the other service areas in the MARCHA operation, and has been expanded to other migrant health centers in the Midwest. Other arrangements similar to this exist in other areas of the country, most operating on a slightly less formal basis.

Impact/Benefits

Benefits of this arrangement accrue to all parties involved: the health center, the Migrant Education program, and the children and their families. If this integrated project were not in place, the following reality would exist:

90-95 of the patient encounters would have had to be provided in the Bangor clinic, using a higher level clinical provider than was actually necessary, rather than at the school using nursing personnel.

MARCHA's Bangor clinic would have been overwhelmed trying to-triage all of these patients and still meet other clinic demands.

5-10 percent of the encounters would have been sent out by NOMAD to private practitioners, requiring a direct outlay of funds on NOMAD's part.

Continuity of care between the school and the clinic would have been nonexistent, with the patient bearing the greatest burden of the lack of coordination.

Stated in the positive, the health center and the patients benefit from the early intervention, the school benefits by saving additional outlay of expense, and all parties benefit from the team's success in responsibly managing the care of a large number of children.

Costs/Financial Savings

Exhibits 1 through 3 present financial information for MARCHA and Project NOMAD. Project NOMAD invests $3,223 and $8,736 in indirect costs for a total of $16,147 per year. MARCHA provides clinical encounters valuing $74,569, of which $67,116.85 are performed on-site at the Bangor school. The balance, $7,452, are provided at the school.

Lessons for Other Migrant Health Centers

One feature stands out among each of the sites selected for evaluation of interagency agreements. This project also reflects the same feature: the credit for this successful interagency relationship goes primarily to the individuals providing the leadership for both organizations. Each has demonstrated longevity with his or her organization and active participation in the community. The personal commitment and vision of these leaders are the key to the implementation of this project. The Board of Directors of the migrant health center has also played an important role in the development of this arrangement as a solution to a previously less than satisfactory relationship.

A sense of each program's well established roots exists within the communities which are served. Each has highly functional teams responsible for implementing the program. Many of the staff of each organization are former migrant farmworkers, and there is a low turnover rate among health professionals working on the joint project.

Exhibit 1

Migrant and Rural Community Health Association
Project NOMAD Resource Costs

Project NOMAD's total resource costs include the direct costs incurred by NOMAD, the allocated costs of the outreach program and the value of referrals to MARCHA's clinics.

Direct Costs

Where identifiable, direct costs are included for both NOMAD and Van Buren Schools. Direct costs are primarily salaries and wages.

Allocation

Outreach total costs not directly chargeable to NOMAD are allocated to NOMAD based upon NOMAD encounters divided by total outreach encounters. This percent was used to apportion outreach costs to NOMAD which were not directly identifiable.

MARCHA costs incurred are allocated to NOMAD based upon the value of NOMAD encounters to the value of MARCHA encounters. The value of each encounter uses a combined weighted average charge for dental and medical visits. The combined weighted average value is divided into the value of all MARCHA encounters to produce a percentage. This percent is considered to be the value of MARCHA's funding used to support NOMAD in excess of the outreach budget.

The weighting method uses referral and total medical and dental encounters.

Exhibit 2

Migrant and Rural Community Health Association
Project NOMAD

Encounters in NOMAD and Outreach					
	learning Center	VoTech Center	NOMAD Total	Outreach	Percent
Medical	450	589	1,039	2,714	.3828
Dental	170	196	366	1,923	.1903
Total	620	784	1,405	4,637	.3030
Referrals					
Medical	53	42	95		
Dental	10	51	61		
Total	63	93	156		

	Encounters	Charges	Average Charge	Weighted Average Charge	Combined Weighted Average Charge
Medical					
Medicaid	5.910	291,540	49.33	10.1s	
Medicare	374	19,635	52.50	.68	
Self Pay	22,435	1,029,190	45.87	35.84	
Total	28,719	1,340,365		46.67	35.04
Dental:					
Medicaid	1,214	64,110	52.81	6.73	
Medicare					
Self Pay	8,318	422,695	SO.82	44.34	
T					12.73
otal	9,532	486,805		51.07	47.77

Value of Referrals and Encounters			
	Combined Referral/ Encounters	Combined Weighted Average Charge	Value
NOMAD	1,561	47.77	$74,569

Exhibit 3

Migrant and Rural Community Health Association Project NOMAD Resource Costs

Resource category	NOMAD Contractual Services	Van Buren Schools (In-Kind)	Total
Salaries/Wages	$ 6.857	$ 3,609	$ 10,466
Fringe Benefits	$ 1,371		$ 1.371
Travel	$ 0	$817	$ 817
	$ 0	$ 0	$ 0
Supplies & Materials	$ 0	$ 0	$ 0
Space	$ 0	$ 19,684	$3,281
Contractual	$ 0	s o	s o
Total Direct	$8,228	$ 7,707	$ 15,935
Indirect Other	$ 1,029	s o	$ 1,029
TOTAL	$ 9,257	$ 7,707	$ 16,147

Plan de Salud del Valle, Inc.
Fort Lupton, Colorado

Summary

Plan de Salud del Valle, Inc. (Salud) was founded in July 1970 in response to health care needs of migrant farmworkers and indigent rural residents in and around Fort Lupton, Colorado, which is located in the fertile Platte Valley northeast of Denver. Originally funded under the Migrant Health Act, the center has evolved into a Community as well as a Migrant health center. Salud provides comprehensive, family-oriented care by a multi-disciplinary health care team on a year-round basis. Salud has four main health centers located in Fort Lupton, Brighton, Frederick, and Commerce City. In addition, it operates an adolescent center in Fort Lupton, three clinics in Hudson, Platteville, and Longmont, and a mobile health unit which is used extensively to provide health services to farmworkers at their labor camps.

Salud has developed a number of excellent collaborative relationships over the years. Three examples of services provided or enhanced through interagency coordination were studied at this site visit: Environmental Health Services, Dental Health Services, and Migrant Head Start These three areas represent the most mature and fully documented collaborative arrangements established by the center. Many other similar working relationships have developed with community agencies and educational and health care institutions; however, most of the agreements are of an informal nature, without contracts or written documentation. The long history behind many of these arrangements is evidence of the success of services integration at Salud.

Background

Salud is located in a rich agricultural valley. The main crops in the area are truck crops, such as lettuce, cabbage, cucumbers, potatoes, squash, and corn, which require extensive manual labor. Consequently, Salud sees a large number of farmworkers. Salud serves a population of about 18,500 users for medical services, and about 5,800 dental users. About 52 percent of the patient population are Hispanic, 42 percent are White, and 2 percent are Black or Native American. About 66 percent of the health center's users have incomes below the poverty level; 23 percent have incomes between 100-200 percent of poverty; and 11 percent have incomes over 200 percent of the poverty level.

Organization and Staffing

Salud's annual operating budget is $4.9 million. Salud's provider staff includes eight physicians (six family practitioners and two pediatricians), twelve mid-level practitioners (nurse practitioners and physician assistants), five and one-half dentists, two dental hygienists, and seven nurses. In addition, Salud offers health education, WIC and nutrition counseling, medical social work, and case management services.

Four senior administrative staff report to the Executive Director: the Director of Operations, the Finance Director, the Medical Services Director, and the Dental Services Director. The Director of Operations is responsible for all support and non-clinical functions, such as outreach services. Along with the Executive Director, he is closely involved in all arrangements and agreements for coordinating service delivery with other agencies. The Medical Services Director oversees Migrant Head Start as well as Environmental Health Services. An organization chart is included as Exhibit 1.

Environmental Health Services

Description

Salud maintains an active Environmental Health Services program which addresses the issues of pesticide exposure, well contamination, and vector control. Salud also provides health education to farmworkers concerning environmental dangers. Perhaps to a greater degree than primary health care, environmental health services depend on developing good coordination with local agencies and an appreciation of the sensitivities of various community groups. For example, Salud has written agreements with Adams, Weld, and Boulder counties to allow Salud clinic staff to visit migrant farmworker housing camps during the growing season to monitor environmental conditions, check for mosquito and encephalitis infestation, and test well and drinking water at work and camp sites.

These activities, and the requisite interagency relationships, could not have been successfully implemented without the enthusiasm and commitment of Salud's Environmental Health Services Coordinator end the support of the Executive Director. Last year, Salud took the initiative by successfully submitting an Environmental Health proposal to be carried out on a statewide basis through the assistance and support of the Colorado Migrant Health Program. This project, funded by the federal Migrant Health Program, will extend Salud's efforts to other parts of the state and will create a Growers' Advisory Council. It is hopedthatthe Council willbecome aforumto give growers constructive input into environmental concerns facing farmworkers in Colorado.

History.

The Environmental Health Coordinator, a physician's assistant, is also in charge of the Migrant Mobile Health Unit, which takes ambulatory health care directly to migrant housing and work sites during the growing season. During trips to the camps, health hazards such as contaminated or standing water, mosquito infestation, and trash and refuse disposal were apparent. The active coordination for health services began about five years ago when the Coordinator introduced some environmental activities to the mobile health unit. By obtaining small grants for these activities, he has been able to spend some time controlling health hazards in the environment rather than on acute medical care.

The program is continually evolving, since changes must be made slowly. The Environmental Health Coordinator and Salud leadership are sensitive to the delicate diplomacy that must be pursued relative to grower involvement in environmental health issues.

Operations

Environmental Health is an integral part of the comprehensive services provided by Salud. The program is included in Salud's health care plan and is a line item in the budget. Environmental health efforts and interventions are included in the regular quality assurance activities of the health center. The Environmental Health Coordinator addresses the board once or twice a year on environmental health issues.

In keeping with the focus on setting realistic objectives, the Environmental Health Coordinator generally works on three to five issues per year. For example, housing is currently a big push, and Salud is working with local consortia to build new housing. Much of the coordination is with county governments. Salud's Environmental Health Coordinator and staff inspect about twenty camps on a weekly basis during the growing season to bring them into closer compliance with county standards. Pesticide awareness involves posting warnings in the fields.

Coordinated relationships with local and state government for providing environmental health services include:

- Boulder County-This is a formal, but unwritten, agreement with Boulder county's housing authority for Salud to provide environmental services to labor camps. Boulder county has also agreed not to use pesticides for mosquitos; Salud uses lacto-bacillus for mosquito control at the camps.
- Weld County—Salud has had a written agreement for five years for Weld county to conduct water tests and some staff training; the agreement provides for 20-40 free tests, but informally the county provides as many tests as needed.
- Adams County-A written agreement allows Salud staff to work at camps. Adams county provides a sanitarian one-half day per week during the summer, and has also provided camps with fish that eat mosquitos.
- State Health Department-An epidemiologist and vector control specialist monitor for encephalitis on an informal, as-needed basis.

Salud also has established relationships with local universities to support its Environmental Health Services program:

- Colorado State University (CSU)—Salud has a formal agreement for interns. Salud's Environmental Health Coordinator serves as a preceptor, and CSU pays the interns' worker's compensation insurance. Interns make weekly checks of conditions at the camps. CSU also provides expensive laboratory work related to pesticide exposure (choline&erase levels) at half-price.

- University of Northern Colorado in Greeley donates computer time on an informal basis.
- University of Colorado Medical School--Provides free literature searches because Salud's Environmental Health Coordinator sometimes serves as a preceptor for its students.

Salud has also obtained some small grants which have facilitated coordination. For example, Salud obtained a grant from the Kaiser Foundation for safe areas, which was used to build three playgrounds in migrant camps. Another small grant provided for a computer and modem to enter and store information from the camps.

Salud is also working on agreements with growers, and is trying to demonstrate that improved conditions in the camps and in the fields will improve productivity. Salud staff approach the growers each spring and ask if they can have access to the workers. They try to keep the process very informal and non-threatening.

Impact/Benefits

Salud's approach has been to focus on discrete, achievable tasks rather than stretching to more complex tasks, issues, and politics that may take awhile to mature. This agenda has substantial support from the Salud administration and clinical staff, and has helped to develop good interagency collaboration. The collaboration has developed to such an extent that, both regionally and nationally, Salud is recognized for pursuing a practical, yet formal, environmental health services program. That credibility is significant to future efforts, both in the region and potentially for leadership efforts nationally on behalf of migrant health centers.

Those who deliver primary care can see the specific benefits of an active environmental services program in the form of decreased and more limited outbreaks of diarrheal epidemics and other diseases.

Costs/Financial Savings

Salud's accounting system has a cost center for environmental health which captures some of the costs provided by Salud for this service. The health center also provides other resources to the program that do not appear in this cost center. These include a portion of the physician assistant's time devoted to environmental health; the cost of transportation for environmental health interns; a portion of the mobile health bus (since environmental health activities, such as water testing, are carried out in conjunction with the bus's visits to migrant camps); the cost of some supplies and laboratory testing which do not appear in the environmental health cost center; and costs for training and continuing education in environmental health.

The costs of resources contributed by other agencies have been estimated based on the negotiated agreements and on informal arrangements which have evolved over time. Resources contributed by county agencies include water testing, sanitarian services,

and staff training. Contributions of other organizations include student interns, computer time, and monitoring of encephalitis and pesticide exposure. These costs have been estimated with the help of the Environmental Health Director. Exhibit 2 shows the costs of the integrated Environmental Health Program at Salud that can be quantified at this time. Since many of the cooperative relationships are informal and are accessed on an as-needed basis, many resources which make this program work are not readily quantifiable.

Lessons for Other Migrant Health Centers

Salud has developed an exemplary environmental health services program which benefits from many successful working relationships with other agencies. The key components—an enthusiastic Coordinator, a supportive Executive Director, and a keen sensitivity to local politics—should serve as model for other migrant health centers. The involvement of a physician's assistant who also provides primary care services facilitates the link between environmental services and preventive health care.

Recommendations

While the degree of university and college involvement in environmental health services is impressive, it is recommended that Salud further pursue recognition of its physician assistant preceptors as affiliated faculty at Colorado State University. This affiliation would provide the benefits of continuing education, access to resources, and status associated with faculty recognition.

Some recommendations for improving Salud's Environmental Health Services program are relevant to other migrant health centers as well. For example, more specific job descriptions outlining responsibilities in the area of environmental health and the establishment of built-in procedures related to pursuing agreements with agencies would strengthen the center's support of environmental health services and streamline the process of integrated services delivery.

It should be noted that Salud's success in this area has required overcoming many barriers. organizationally, responsibility for environmental health issues is fragmented and confusing, both at the local level and at the federal level. It was suggested that a, federal coordinator for environmental health would help to make a strong statement for migrant and environmental concerns, especially regarding pesticides. Also, the requirement that each migrant health project have an environmental services component should be stated more clearly and forcefully.

The BCRR system does not give a project "credit" for its environmental health activities. For example, there is no way to record an encounter for water testing by an environmental health worker. When primary care providers are involved in environmental health activities, they can produce fewer patient encounters for direct primary care. This results in lower productivity statistics, even though the environmental health activities may actually improve the health of a greater number of people.

Dental Services at Plan de Salud del Valle

Description

The provision of dental services to migrant farmworkers by Salud is an excellent example of coordination, using staff and resources from several organizations to meet mutual goals. Both the Migrant Education and Migrant Head Start programs have mandates to provide dental screening and preventive dental services to children enrolled in their programs. However, these programs must rely on state and community resources to provide dental care. Salud is committed to providing comprehensive dental care to migrant farmworkers. While it has dental health professionals and facilities, Salud's ability to identify and bring to its dental clinics all of the farmworkers in need of dental care is limited without the participation of other programs which serve farmworkers.

The focus of this coordinated effort is to augment the regular Salud staff and resources during the summer months. This is accomplished by on-going coordination, including formal interagency agreements and long-standing working relationships, with:

- Colorado Migrant Health Rogram (CMHP) of the State Department of Health
- Migrant Head Start
- University of Colorado
- Northwestern University School of Dentistry
- University of Iowa School of Dentistry

CMHP is a key player in the coordination of dental services to farmworkers throughout the state. The on-going relationship with the Salud clinics has facilitated the delivery of dental services to farmworkers in the northern part of the state. The Colorado Department of Health's Migrant Health Program uses funding from the federal Migrant Health Rogram, Colorado's Maternal and Child Health Block Grant, and the national Migrant Education Rogram (through the Colorado Department of Education) to support the provision of dental services to children in Migrant Head Start and Migrant Education. In the case of Migrant Education, CMHP has contracted directly with Salud for dental services. As part of this contract, CMHP recruits hygienists and dental students, orients staff, and provides a portion of the hygienists' salaries and equipment.

Through an agreement with Family Education Network of Weld County (FENWC), CMHP provides dental hygienists for the Greeley, Fort Collins, and Alamosa Head Start sites. CMHP also provides dental students or recent dental graduates for these sites.

A purchase-of-services contract between Salud and FENWC, the local Migrant Head Start grantee, provides for FENWC to transport its children to the health center to meet their scheduled dentist appointments. Under this agreement, the health center

provides prophylactic therapy and application of topical fluoride for each FENWC child. Salud also provides all restoration and/or extractions determined necessary for each child. The health center is reimbursed a set amount ($30.00 in FY 1990) for each FENWC child served.

In the past year, Salud dentists served as preceptors to at least twelve dental students or recent dental graduates, whose stipends were paid by their schools. Receptorships for University of Colorado students are coordinated through the CMHP, which contracts with the dental school and places students throughout the state. In addition, Salud has established relationships with the Schools of Dentistry at Northwestern University and the University of Iowa to recruit dental students for summer preceptorships. All of Salud's staff dentists have faculty appointments at the University of Colorado Health Sciences Center School of Dentistry.

History

Dental services were a state program administered by CMHP before Salud was founded. In the early 1970s, Salud's Director of Dental Services made use of the network that existed for providing dental services to migrant school children. It took about two years for him to develop a smoothly running coordinated service. This individual still serves as Salud's Director of Dental Services. The Dental Health Consultant at CMHP has been with the state program since before 1970. Thus, a long-standing working relationship, with years of experience in coordinating dental services, exists between Salud and CMHP. The leadership of these individuals, the continued interest of the dental schools, and the personal commitment of each service provider were cited as keys to the success of this program. The current network of agreements and level of operations has existed since 1982.

Barriers encountered relate to insufficient time and resources. The migrant schools were limited to terms of 5-7 weeks last summer due to funding constraints. This is a frustration for the dental staff, who feel pressured to complete treatment in a short time. At the same time, staff of the Migrant Education and Head Start programs do not want their students to miss too much school time for dental visits; especially since the school session is already abbreviated. This can sometimes lead to conflicts between school and dental personnel. Problems were also noted in reaching adolescents, since they may not attend school every day. Besides understanding the other perspective, the best way to overcome this problem has been through careful scheduling and tracking of patients to minimize unnecessary appointments or waiting.

Another barrier encountered in earlier years was the instability of the local Migrant Head Start Program, because the grantee kept changing. However, the situation seems to have stabilized with FENWC.

It has been difficult to get additional resources to serve adult farmworkers, since the Migrant Health Program requires only preventive dental services and the Migrant Education and Migrant Head Start programs only address children. There is little third party coverage for dental services, adding another dis-incentive for the provision of

comprehensive dental care. The support and commitment of the Executive Director has been especially important in overcoming these barriers to serving adult farmworkers.

Over time, changes have occurred as Salud and its partners have learned to make the system work better. For example, they learned that having evening clinic hours did not improve access for farmworkers unless transportation was available as well. They learned that a mechanism was needed to enable patients to pay during evening clinic hours, but that such a system had to be carefully conveyed to staff so that patients were not made to feel that they had to pay at time of their appointment.

Operations

Salud's dental component operates at three clinic sites: Fort Lupton, Frederick, and Commerce City. Salud counts 83,366 people living in its catchment area who could access dental services. During calendar year 1990, the Salud dental clinics saw 1,525 migrant or seasonal farmworkers (26 percent of all dental users) for a total of 4,226 encounters (29 percent of all dental encounters). During the summer, all of Salud's dental clinics are open in the evenings and most of the available clinic time is allocated to farmworkers. In addition, a hygienist works full-time in each of the six migrant schools and in the Migrant Head Start centers. During the summer months, Salud also operates a mobile dental unit which visits migrant camps one night per week

The following table compares regular staffing and summer staffing for dental services:

Type of Provider	Regular	Summer
Dentists	4	4
Hygienists	2	6
Dental Assistants	9	14
Dental Students	0	6

Impact/Benefits

This program has positive benefits for all participating agencies. The Migrant Head Start Rogram and the Migrant Education Rogram are assured that their children will receive dental care above that mandated in the legislation, at a cost per child which is substantially less than charges for comparable services in the private sector (see next section). Of 399 children attending Head Start School in 1990,335 (96 percent) received dental prevention services. 199 were referred for care, and all received services. Of the 753 migrant school children in Salud's target area, 720 (96 percent) received dental prevention services (Salud Continuation Grant Application, FY 1992).

Salud's efforts to provide comprehensive dental care to all migrant families are aided considerably by the health center's relationships with Migrant Head Start, Migrant Education, and several dental schools. Through on-site screening and preventive dental services at each Head Start and Migrant Education school, children in need of care are readily identified. Consent forms and histories are completed at the school

sites. The sites also provide transportation to the Salud clinics and an aide to accompany students to the clinic and supervise them while they await their appointments. This enables the Salud dental staff to focus on the provision of dental services, thus increasing their productivity.

Costs/Financial Savings

Data on Mud's cost of dental services were provided by the center's computerized accounting and management information systems, and are summarized in Exhibit 3. The accounting system includes a separate cost center for dental services. In order to allocate an appropriate proportion of the total dental costs to services provided to farmworkers, the ratio of migrant encounters to total encounters (25 percent) was used.

Resources provided by the CMHP were estimated by the dental health consultant. Costs of some of these resources were not readily available, and therefore were estimated by the dental health consultant.

Salud uses usual and customary fees for the local area to value the services it provides. Using this method, the value of services provided to children in the migrant education program in 1990 was estimated to be $98,819. The actual amount paid by CMHP for this treatment was $10,827 (Final Report, Migrant Education Program, 1990). A total of 2,327 dental encounters were provided to farmworkers during the summer of 1990, at an average value per unit of service of $57.02, resulting in a total estimated value of services provided to farmworkers of $132,690.

At least during the migrant season, Community Health Center (Section 330) funding probably subsidizes Migrant Health Center (Section 329) funding to provide the dental services component at Salud. However, having the joint funding improves services for both farmworkers and community residents because it provides the "critical mass" needed to provide comprehensive service delivery. Even with the expanded service during migrant season, Salud's dental costs increase by only 10 percent during the summer because of the interagency agreements and collaborative efforts which contribute to the provision of dental services for farmworkers.

Many aspects of this coordinated activity are not readily quantifiable. Nevertheless, they are important characteristics of this system. For example, the impact of access to an already identified and supervised population at the Head Start sites and at the migrant schools cannot be fully measured. The type and extent of a program that would evolve if the health center were to attempt to identify and schedule appointments with each of these children individually, without coordination with the Head Start and Migrant Education Programs, is hard to imagine, let alone quantify. The use of dental students, besides the value of services contributed, has other benefits more difficult to quantify, such as maintaining an excellent relationship with the dental schools. This is important professionally for the dentists, and affects recruitment and retention of professional staff, the ability to make referrals for more complicated cases, and involvement in continuing education and quality assurance activities.

Lessons for Other Migrant Health Centers

It is important for health centers to "leverage" what they have that is of value to others. For example, because Salud has excellent dental services, available at several locations, CMHP views Salud as a resource for providing services to the migrant schools. Similarly, because the dental practice at Salud provides an excellent experience for students and Salud's dentists have been good preceptors, the Schools of Dentistry have continued to send students to work at Salud.

Finally, long-term working relationships and leadership committed to migrant health are key components of this successful program.

Migrant Head Start Health Services

Description

Salud's coordination with the Migrant Head Start program provides on-site primary health care for Migrant Head Start children. The Migrant Head Start program involves two sites: a school in Frederick and an additional site in Brighton, which serves as a satellite of Frederick A Head Start nurse at the site screens children and coordinates their care with Salud's medical staff. Salud medical staff also supervise University of Colorado Physician Assistant Program students when they work at the Head Start sites.

History

Mud's involvement with Migrant Head Start began in the early 1980s when the original Colorado Migrant Council had a day care center for children five years old and younger. In 1984, the Salud clinic, in particular the physician's assistant, were seeing children who were ill and were getting calls to go to the day care center to provide care to sick children. The physician's assistant personally tracked down outbreaks of gastrointestinal distress among the children and discovered that the one thing they all had in common was the day care site. The physician's assistant offered to go to the day care site as needed to assist staff in seeing children and to discuss health procedures and protocols. This proactive effort served to establish an informal working relationship between the day care center and the Salud clinic. Working together has helped to conquer problems of unsanitary conditions at the day care center, and has established preventive health intervention on behalf of the migrant children involved. In about 1985, the Migrant Council that ran the day care center disbanded and the Colorado Department of Health took over the day care program, working with Migrant Head Start. Salud was invited to become involved in establishing protocols and a formal relationship to provide care. This arrangement has remained fairly stable over the last several years.

Operations

The Migrant Head Start Medical Director, who is also Salud's Medical Director, and a physician's assistant based at the Frederick site are the two key Salud staff involved in this program. The Migrant Head Start health program begins at the start of the season. Head Start staff, state migrant health staff, and local school district staff serve as outreach workers. They visit migrant camps, seek out women and children and register them for Migrant Head Start, arrange transportation, and provide a fundamental screening and history for each child they can discover. An on-site bilingual nurse who is a paid employee of Migrant Head Start sets up systems for screening every morning. The nurse also indicates when home visits are necessary and conducts home visits. The nurse directs the communication, coordination, and triage system that interfaces with the Salud clinical staff.

All patient encounters are provided by Salud's physician and physician's assistant at the Migrant Head Start sites. They meet with children during regularly scheduled hours based upon the initial triage of the on-site nurse. Any referrals to laboratory, x-ray, or specific consultations take place away from the Head Start site and may involve the Salud clinic or other referral sites. Medical records on each child are kept at the school by the Head Start nurse.

Impact/Benefits

This program highlights some of the most important benefits of service integration: convenience for patients and providers, and continuity of care. The program allows migrant children to stay in school and be treated for illness on-site. The children do not miss school and the parents do not lose income by having to take a sick child to the clinic. The on-site nurse coordinates the care for each child, from triage to home visits. This continuity of care is enhanced because everyone at the school knows the children, and all children have been effectively screened at the start of the program. For Salud, the "captive" population saves overhead and allows much more efficient access to the patients (e.g., fewer missed appointments or patient tracking problems). For example, 100 percent of the children enrolled in Migrant Head Start are immunized.

Costs/Financial Savings

The costs of the health services provided to Migrant Head Start by Salud were estimated based on the staff time devoted to Head Start encounters and an estimate of cost per encounter for supplies and other direct costs. The costs of dental services are excluded, as they are covered in the analysis of Salud's dental services component.

The costs of services provided by Migrant Head Start and summarized in Exhibit 4 were obtained primarily from the written agreement between the Family-Educational Network of Weld County (FENWC) and the Colorado Department of Health's Migrant Health Program. Some additional costs, such as the maintenance of medical records at the Head Start sites and transportation between Head Start sites and clinics, were

estimated based on interviews with the Head Start Health Coordinator and the Head Start Medical Director. Salud's contract with Migrant Head Start provided for payment to Salud of $25 per child for medical services and $10 per child for health assessment, up to a total of $1,250 in 1990. The value of services (based on usual and customary charges) provided to Head Start children by Salud is more than the reimbursement provided by Head Start Although Salud can bill Medicaid for additional services provided to those children who are Medicaid eligible, it still appears that Migrant Head Start is receiving services at a substantial savings.

Lessons for Other Migrant Health Centers

A program like this, which enhances access for patients and providers, can improve productivity and improve the effective delivery of essential preventive and acute health care services. One concern of the staff is that many of the health problems they see have a direct environmental relationship (e.g., tooth decay, parasites), indicating that more emphasis needs to be placed on educational efforts. The case management/coordination of care approach of this program may provide an opportunity to reach families through their children and thus facilitate such health education initiatives.

Recommendations

It is suggested that data on the value of services provided to Head Start children be documented and communicated to Migrant Head Start on an annual basis in order to better evaluate Salud's contributions to this program. By gradually working towards an activity-based costing of this and other coordinated services, Salud will be in a better position to track the dollar value of its services and leverage the impact of its coordinated service agreements.

Exhibit 1

Plan de Salud del Valle
Organizational Chart

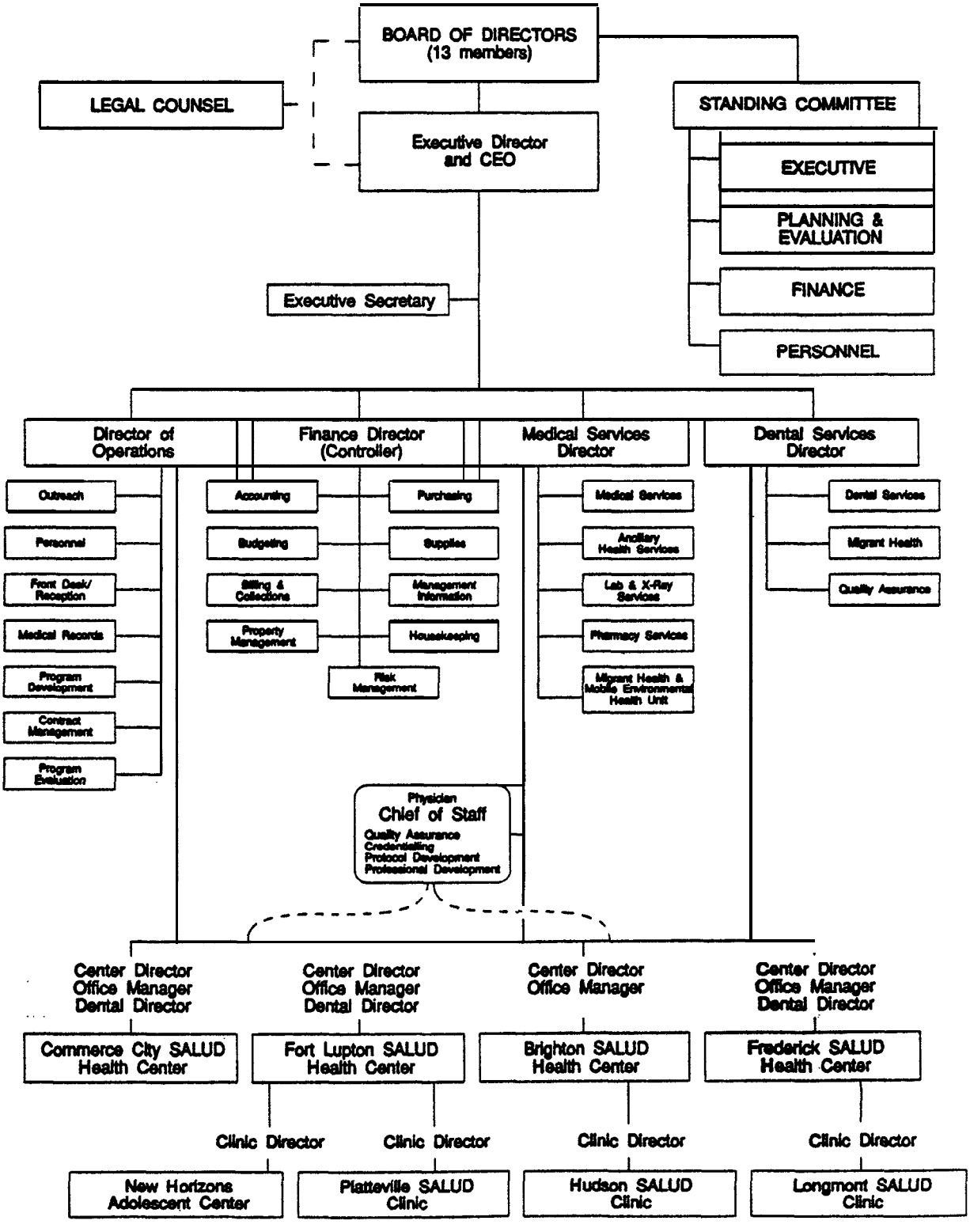


Exhibit 2

Environmental Health Services (1) Integrated Services Costs

Resource Category	Salud	Weld Co. HD	Tri-Co. HD	CO state Univ.	Univ. N. CO	U.CO HSC	Total Costs
Personnel							
Environmental Tech. (2)			$732				$ 732
Environmental Hlth. Coord. (3)	$ 12,172						$ 12,172
Environmental Hlth. Intern (4)	$ 2,375			$ 1,000			$ 3,375
Fringe on employees (5)	$ 3,200		$ 161	$ 220			$3,581
Materials and Supplies							
Drinking water (6)	$ 300						$300
Medical/lab supplies (7)	$1,000						$ 1,000
Other Direct							
Water tests (8)		$ 950					$ 950
Training/consultation (7.8)	$ 1,000	$ 360		$ 400			$ 1.760
Lab tests • pesticide exp. (7)	$170			$ 200			$ 370
Vector control (7)	$ 100		$ 400				$ 500
Transp. - staff & interns (7)	$ 1,000						$ 1,000
Computer time (7)	$ 100				$ 200		$ 300
Lit. searches/library svcs. (8)						$ 100	$ 100
Space (9)							
Equipment							
Mobile health unit (7)	$ 1,000						$ 1,000
Subtotal	$ 22,417	$1.310	$1.293	$ 1.820	$ 200	$ 100	$27,140
Administration (10)	$ 4,314						$ 4,314
Overhead (10,11)	$ 2,000	$236	$ 233	$ 328	$ 36	$18	$ 2,850
TOTAL	$28.7311	$ 1,546	$ 1,526	$ 2,148	$ 236	$ 118	$ 34,305

Notes:

(1) Most environmental health services costs are incurred during the 4-month growing season since activities are directed to migrant housing and migrant labor camps. Administrative, research, and coordination activities are year-round. Costs reported are for FY 1990 (June 1, 1989–May 31, 1990). Salud was awarded a U.S. Public Health Service grant to administer and conduct a statewide Environmental Health Service Program. The grant provides $100,000/year for 3 years and includes a subcontract with the Colorado Migrant Health Program (U-IMP). Since this grant began in October 1990, costs associated with this project are excluded.

(2) Based on $12.50/hour one-half day per week for 12 weeks.

(3) Approximately one-third of time devoted to environmental health. Source: 12/90 BCRR report.

(4) For one intern. Source: 12/90 BCRR report. Colorado State University costs are for in-kind administrative services.

(5) Based on 22% fringe as stated in Salud continuation grant application.

(6) Provided to sites until contaminated water is treated and reevaluated.

(7) Estimates for Salud provided by Salud's Director of Operations.

(8) Estimated provided by Salud's Environmental Health Coordinator.

(9) Other than portion of mobile van, dedicated space is limited. Cost of space is considered to be included in overhead.

(10) Source: 12/90 BCRR report and Salud's Director of Operations. Two allocations are used, one for administration and one for overhead.

(11) for other than Salud. based on indirect cost rate of 18%.

Exhibit 3

Dental Health Services (1)
Integrated Services Costs

Resource Category	Salud	Migrant HS	CMHP	Univ. CO	NWestern Univ.	Univ. IA	Total Costs
Personnel							
Dentists (2)	$ 55,000		$ 3,525				$58,525
Dental Hygienists (2,3)	$ 5,000		$ 16,000				$21,000
Dental Assistants (4)			$ 10,000				$ 10,000
Dental Students (5)			$ 1,000	$ 2,000	$ 5,000	$ 2,000	$ 10,000
Transportation Aides (3)		$6,000					$ 6:000
Program Admin. Staff (3)			$ 5.000				$ 5,000
Fringe on employees (6)	$ 13,200	$ 1,320	$ 7,816				$ 22,336
Materials and Supplies							
Dental van supplies (3)			$ 2,000				$ 2,000
Hygienist supplies (3)			$ 1,000				$ 1,000
Dental clinic supplies (7)	$ 17,000						$ 17,000
Other Direct							
Search/recruitment (8)			$ 300	$ 300			$600
Orientation (8)			$ 2,600				$2,600
Transportation (9)	$ 250	$ 6,000					$6.250
Space (10)	$ 10,000	$ 9,000					$ 19.000
Equipment							
Dental van (11)			$ 2.100				$ 2.100
Subtotal	$ 100,450	$ 22,320	$ 51,341	$ 2.300	$5.000	$ $2.000	$183,411
Overhead (12)	$ 16,072	$ 4,018	$ 5,134	$414	$ 900	$360	$ 26,898
TOTAL	$ 116,522	$ 26,338	$ 56,475	$ 2.714	$ 5,900	$ 2,360	$210,308

Notes:

(1) This analysis applies to the augmentation of staff and programs to provide dental services to migrants during the summer months, including adult migrants and children enrolled in Migrant Head Start and Migrant Education.

(2) Estimate for Salud dentists based on annual salary of $55,000 for 4 FTEs for 3 months. Cost of Colorado Migrant Health Program dentist for van estimated by CMHP Dental Health Consultant. Cost of Salud dental hygienist for services at Title I school.

(3) Source: estimate by CMHP Dental Health Consultant.

(4) CMHP Dental Health Consultant indicated 6 dental assistants, but cost estimate was not provided.

(5) $1,000 per student per CMHP Dental Health Consultant.

(6) Assumes 22% fringe based on Salud continuation grant application.

(7) Estimates for Salud based on 25% of supply costs reported in dental services cost center.

(8) Estimates of donated time/services provided by CMHP Dental Health Consultant.

(9) Salud transportation allowance for dental students. Bus to transport children from migrant schools to clinic estimated at $2,000 per site in interviews with Title I administrator.

(10) Refers to dental clinic space at three sites and hygienist space at 3 schools, Salud space cost estimated as a portion of all rental commitments. Hygienist space estimated at $1 ,000/month/site for 3 sites.

(11) Includes CMHP estimate of cost of donated van plus insurance and moving costs.

(12) Based on an indirect cost rate of 16% for Salud and 18% for all others except CMHP, which uses a rate of 10% on contracts.

Migrant HS = Weld County Div. of Human Resources' Family Educational Network of Weld County Head Start Program, "FENWC"

CMHP = Colorado Migrant Health Program (state health department)

Exhibit 4

Health Services for Migrant Head Start (1) Integrated Services Costs

Resource Category	Salud	Migrant HS	CMHP	Univ. CO	Total costs
Personnel					
Case manager/nurse (2)		$ 2,684	$ 7,675		$ 10,359
Outreach worker (3)		$ 3,200			$ 3,200
Physician (4)	$ 5,000				$ 5.000
Physician assistant (5)	$ 3,000				$ 3:ooo
Fringe on employees (6)	$ 1,760		$ 1.689		$ 3,449
Phys. asst. students (7)				$ 2,000	$ 2,000
Materials and Supplies					
Medical supplies	$ 1,200	$ 1,200			$ 2.400
Other Direct					
Space at two day care centers (8)		$ 8,000			$ 8.000
Equipment		$ 3,000			$ 3,000
Overhead/Admin. (9)	$ 1,754	$ 3,255	$ 1,685	$ 360	$ 7,054
Other					
TOTAL	$12,714	$21,339	$ 11,049 I	$2,360	$47,462

Notes:

(1) Contract between Salud and FENWC indicates that Salud will provide health services at 2 FENWC centers, Frederick and Brighton. Cost estimates are based on 2 centers for a 4-month period during which this integrated service operates.

(2) Assumes case managers are nurses. Assumes 1 FTE nurse at each site for 4 months. .5 FTE nurse actually provided by Salud but reimbursed by FENWC per contract at $671/mo. to a maximum of $2,684. Estimate of 1.5 FTE nurse provided by CMHP based on interview with Weld Co. Migrant Head Start Health Coordinator inditing generally the proportion paid by CMHP and Migrant Head Start. State health department rate for nursing services is $7.38/hr.

(3) Assumes 1 FTE outreach worker per site at $100/week each. Estimate provided by Title I administrator during interview.

(4) Estimate ot time by Salud's Director of Operations. Assumes annual physician salary of $60,000.

(5) Estimate ot time by Salud's Director of Operations. Assumes annual PA salary of $30,000.

(6) Assumes 22% fringe based on Salud continuation grant application.

(7) Interviews indicate PA students work in this program. Assumed 2 students at $1,000 each.

(8) Based on $1 ,000/month/site.

(9) Salud's overhead rate is 16%. State health department uses an indirect cost rate of 18% for admin. in its contract with Migrant Head Start.

Migrant HS = Weld County Div. of Human Resources' Family Educational Network of Weld County Head Start Program, 'FENWC'

CMHP = Colorado Migrant Health Program (state health department)

Tri-County Community Health Center
Newton Grove, North Carolina

Summary

Tri-County Community Health Center (Tri-County) is a single-site, year-round migrant health center located in Newton Grove, North Carolina. This site serves three contiguous southeastern North Carolina counties. Coordinated services examined during this site visit included a perinatal program and a substance abuse program.

Tri-County's Perinatal Program is a comprehensive case management program modeled after "Baby Love," the North Carolina Medicaid model. This program was originally started by a grant from the Migrant Benevolent Association, a local foundation which received a start-up grant from the K. B. Reynolds Foundation for provision of perinatal services. The health center provides comprehensive case management to virtually 100 percent of the pregnant women who use the health center. The health center has developed key relationships with agencies in three counties, including two county hospitals, the North Carolina Memorial Hospital in Chapel Hill, and several valuable affiliations with other agencies and organizations in the tri-county region.

The substance abuse program at TX-County is about one and one-half years old. This program provides substance abuse screening and counseling for health center patients on-site and through camp outreach services. In addition, the program provides "Driving Under the Influence" educational traffic schools, a "Farmers In Prevention" program targeted at generating grower support for substance abuse prevention, and programs at two local schools. The program as a whole is well integrated within the full scope of services of the health center. The primary growth and success of the program is attributable to at least two key factors: 1) the funding from a local foundation, the Migrant Benevolent Association, for start-up and on-going support, and 2) the strategic, assertive efforts of the Program Director, who has been with the program since inception. Although the program is rather diversified in terms of efforts and activities, the Farmers in Prevention model being developed by Tri-County represents a national leadership effort towards greater grower involvement with issues of migrant health.

Background

'IX-County is a year-round 329-funded health center providing comprehensive health care at a single site. The catchment area constitutes three contiguous counties in southeastern North Carolina: Johnston, Sampson, and Hamett. These three counties provide limited services for migrant and seasonal agricultural workers, and it is only through the assertive leadership efforts of Tri-County that any county services have been leveraged.

Tri-County began in 1976 as a limited-service evening clinic of the Sampson County Health Department, and became a freestanding site operating out of a converted

storefront in 1978. The demand for services was substantial, so that by 1963 Tri-County Community Health Center had constructed and taken possession of its current site. The health center is located in a remote rural agricultural community, 10 miles from the nearest small town and approximately 50 miles south of Raleigh, the state capital and nearest major city. The Tri-County area is a designated migrant impact area.

Seasonal agricultural population totals a little over 17,000, while the migrant farmworker population totals approximately 10,000. TX-County estimates that it serves approximately 9 percent of the seasonal agricultural worker population and about 79 percent of the migrant farmworker population. Of the populations they serve, 98 percent are under poverty level, while 2 percent are within 100-200 percent of poverty. The ethnic breakdown of the migrant farmworker population served by Tri-County is estimated to be about 65 percent Hispanic, 32 percent Black American, .5 percent Haitian, and 2.5 percent White.

The Tri-County site is on a county road several miles outside the small rural town of Newton Grove, North Carolina. The site serves its patients from three buildings: a medical facility, a dental administrative facility and a third administrative building. The clinic site provides primary health care; preventive care and health education; a laboratory and x-ray facility; preventive dentistry with two dentists, a hygienist, and a dental assistant; a pharmacy; a transportation van and migrant outreach program; and two well-defined coordinated programs in perinatal and substance abuse. The clinic's programs are hampered by their lack of a formal transportation system in the three counties, and by limited cooperation from the three county health departments. For example, although there are four hospitals within the catchment area, only two hospitals will work in any collaborative way with Tri-County, and only one of the hospitals currently provides Tri-County physicians with admitting privileges. While the clinical and administrative staff and board members of Tri-County continue to develop working relationships with all three county resources, it is apparent that county cooperation on behalf of access to health care for farmworkers is limited.

Organization and Staffing

Tri-County is governed by a 13-member community board, of which seven members are current users of the center. While the administrative structure of the center follows fairly traditional lines, the administrator has provided significant control and decentralized authority to the Medical Director for Clinical Affairs. The Executive Director has been with the program since 1985 and has a private sector background in finance. The Medical Director is a pediatrician who has been with the center since 1989. The Medical Director assumes administrative responsibility for all providers. The nursing department, allied health department, pharmacy, dental unit, and front desk are administered by separate department heads.

Reporting directly to the Executive Director is an Office Manager and Finance Officer with an accounting background who has been with the clinic since 1968. In 1992

'D-i-County will receive some $1,200,000 in federal Section 329 migrant health monies, with applicant and other funding making up the balance for a gross operating budget of $1.5 million. Core clinical staff consists of three FTE physicians, one FTE family nurse practitioner, one FTE physician's assistant, and two full-time dentists. All of the key clinical staff have started employment at Tri-County within the last two years, reflecting in part the difficulty Tri-County faces in recruiting qualified clinical professionals to an isolated rural area.

The development and expansion of integrated and coordinated services with agencies and organizations in the catchment area is approached in a team manner, with the Executive Director comfortable in allowing key staff members to approach outside agencies and introduce ideas for extending integrated services. While the Executive Director serves to finalize formal contracts, agreements and fundingrelationships, and serves as the liaison to obtain formal board approval, the organization as a whole is quite comfortable allowing its professional and department heads at all levels to approach and develop potential relationships.

Two of the counties served have had migrant coordinating councils. In Sampson county the council has recently been revitalized and is meeting on a regular basis to discuss issues of integrated services to migrant farmworkers. In Johnston county the migrant coordinating council has not met for some time, and it is the long-term intention of Tri-County to reactivate that council.

Despite difficulty gaining cooperation of county agencies and organizations in the catchment area, Tri-County has been able to develop a comprehensive case-managed perinatal program which provides case management for 100 percent of the pregnant users of the center. The substance abuse program, while a relatively new program, continues to make headway in attracting cooperation and attention from county mental health agencies and other related agencies in the catchment area. Given the overall lack of community responsiveness to farmworker health issues, it appearsthat Tri-County is at present maximizing the potential for its coordinated relationships with the agencies in the catchment area. However, these relationships would not be at their present level of maturity were it not for the influence of the Migrant Benevolent Association, a local foundation that provided support for the perinatal program start-up as well as on-going support for the substance abuse program.

Perinatai Program

Description

The perinatal program at Tri-County provides or arranges for comprehensive prenatal care from the point at which pregnancy is confirmed through six weeks postpartum. Using an intensive case management approach, the program successfully follows patients closely and assures that services are received, despite varying resources, requirements, and degrees of cooperation from the neighboring counties. The program is modeled after Baby Love, North Carolina's Medicaid-reimbursable model, which

covers a number of comprehensive and support services in addition to traditional medical-oriented prenatal care. These include transportation, prenatal education, nutrition counseling, and case management.

Medicaid eligibility and care for uninsured women is provided through agreements with three county health departments. Harnett county has no perinatal program. Most farmworkers served are residents of Sampson or Johnston counties. Sampson Memorial Hospital and Johnston Memorial Hospital are small county hospitals. Both have obstetrics departments, but 'IX-County physicians are unable to obtain admitting privileges to these hospitals because of distance (about 25 miles). TX-County also uses North Carolina Memorial Hospital in Chapel Hill (about 75 miles away) for high risk cases. There is only one obstetrician at Sampson County Memorial Hospital.

The distances and varying jurisdictions covered have resulted in unique coordination arrangements in order to assure continuity of care and in-patient obstetrical coverage for Tri-County patients. For example, there is a formal agreement between the Johnston County Health Department and the physician at Tri-County who is responsible for perinatal care. This agreement provides for participation of Tri-County in the state's coverage plan for rural obstetrical care. Under this agreement, Tri-County's physician provides out-patient perinatal care and the county pays the physician's liability insurance premium differential for obstetrics. If a patient resides in Johnston county, she receives her prenatal care from TX-County and delivers at Johnston County Memorial Hospital. If a patient resides in Sampson county, she is referred to the county health department after her first visit; she receives all of her medical prenatal care from the county health department, but case management and support services are provided by T&County. The patient delivers at Sampson Memorial Hospital.

In addition to the county health departments, Tri-County has on-going cooperative relationships through its Maternity Care Coordinator with:

- The Love and Help Association-informal referral to shelter for the homeless
- Harbor, Inc.-services to victims of rape and domestic violence
- State Medicaid agency
- County Departments of Social Service (DSS)—Johnston county DSS comes to Tri-County every two weeks to take Medicaid applications
- WIC-provided on site; nutritionist is funded 50 percent by WIC and 50 percent by Section 329 funds
- Substance abuse screening and counseling-available on site
- Duke University (Medical School and Center for Documentary Studies), Campbell University (School of Social Work), University of North Carolina (School of Public Health), North Carolina Central University (School of Social Work), East Carolina University (School of Nursing&student interns

History

The perinatal and transportation program was started by the Migrant Benevolent Association, which received a one-time $129,000 grant from the K. B. Reynolds Foundation. Through this grant, the Association provided TX-County with a nurse practitioner, coordination, and transportation. Later on, Tri-County received a Comprehensive Perinatal Care Program (CPCP) grant for $36,000. The Reynolds grant ended, but the CPCP funds from the federal government have increased to $57,000, which constitutes the program's current operating budget.

One barrier faced by the program is that each county has different requirements. Over time, acceptable arrangements have been worked out with each, but the relationship with Sampson county continues to be more strained. Since Medicaid does not cover individuals without residency status, many migrant farmworkers are not eligible for Medicaid. This creates a barrier when referring patients to the county health department because there is a risk that the patient's care will not be covered by Medicaid. As part of its coordination agreement, Tri-County pays the Sampson County Health Department $2,500 per year to cover those patients who do not qualify for payment.

Language is another barrier which the perinatal program tries to overcome. The Maternity Care Coordinator and most of the 'IX-County staff are bilingual. However, the Sampson County Health Department won't see any Spanish-speaking patients (due to lack of bilingual staff) unless they are referred by 'IX-County's Maternity Care Coordinator.

Transportation is another barrier which Tri-County works hard to overcome. Tri-County has its own van and driver specifically for the perinatal program. This van makes regular trips within a SO-mile radius between patients' homes, Tri-County, and Sampson and Johnston County Health Departments. Tri-County also provides regular transportation to Chapel Hill.

Operations

The cornerstone of this program is the Maternity Care Coordinator. The current Coordinator was employed in February 1991. However, many of the protocols were already in place, allowing the program to continue smoothly and to expand as a result of the energy and commitment of the new Coordinator. The basic flow for perinatal care at the health center is as follows:

- At the first visit, after the medical exam, the patient sees the Maternity Care Coordinator. The Coordinator completes a patient history and assessment, and explains the perinatal care program and specific arrangements for where to obtain care (depending on the patient's county of residence). The Coordinator also screens for substance abuse and HIV risk Finally, she obtains directions to the patient's home and sets up the next appointment, If indicated, the Coordinator also makes referrals for nutrition counseling, substance abuse counseling, and HIV testing,

- At the first visit, the patient also sees the nutritionist. One goal of the perinatal program is to have all patients enrolled in WIC at their first visit.
- The system is set up such that the last stop on all future prenatal visits is with the Maternity Care Coordinator. If the patient is a resident of Johnston county, she continues to receive all prenatal care at Tri-County. If a resident of Sampson county, she will receive prenatal care at the county health department. The Maternity Care Coordinator sets up the appointment and continues to serve as her case manager. She will continue to receive other services (e.g., education, counseling) through Tri-County.
- For Johnston county residents, the Maternity Care Coordinator sends the patient's prenatal records to the hospital every trimester. 'K-County pre-registers the patient and she delivers at Johnston Memorial Hospital, attended by that hospital's obstetrician. Tri-County also coordinates high risk cases with this obstetrician to determine whether the patient can be handled by Johnston county or should be referred to Chapel Hill. The hospital informs the health center of the birth, and the health center schedules a two-week postpartum appointment. The Maternity Care Coordinator tries to visit as many patients as possible while they are in the hospital to overcome any language barriers, promote breastfeeding, and encourage follow-up care.
- At six weeks, the mother and child receive complete assessments.

The Maternity Care Coordinator or the Maternity Care Clerk follows up on all missed appointments. WIC is a strong incentive for women to return for pre- and post-natal visits; vouchers for prenatal patients are only issued for one month, encouraging them to return to the clinic. Voucher pick-up is coordinated with prenatal visits and well child care. The WIC clerk coordinates this scheduling and ensures that addresses and other contact information are kept up to date. Home visits, generally by student interns, are conducted as needed. The program has had students from Duke University's Center for Documentary Studies and from the University of North Carolina School of Public Health. Basic nutrition education is provided by the Maternity Care Coordinator. Patients are referred to the nutritionist if there is a particular issue of concern, such as diabetes or weight gain.

Impact/Benefits

In the nine-month period between January 1 and September 30, 1990, Tri-County served 170 perinatal users; there were 50 deliveries during that period. Of these, there was only one low birthweight infant (under 2500 grams) and one fetal death. In 1990-91, 56 percent of prenatal clients enrolled in prenatal care during their first trimester. Ninety percent of prenatal users were screened for substance abuse. Of those identified as using alcohol, drugs, or tobacco, 70 percent were referred to the substance abuse program for counseling. About 5 percent of prenatal patients at Tri-County are considered high-risk and are referred for assessment by the Johnston county obstetrician. Over half (53 percent) of all prenatal clients received a home visit in 1990-91.

The program is growing. The Maternity Care Coordinator estimates about 300 perinatal users this year. There were 137 prenatal encounters in May 1991, and 187 in June. During this two-month period, 49 patients were provided transportation by the health center.

The most significant impact of this program is its ability to closely follow all of the patients identified. Of the seasonal workers, 100 percent receive case management throughout the perinatal period. For migrant workers it is not always possible to see patients throughout the entire pregnancy. In these cases the Maternity Care Coordinator contacts the health center nearest the patient's next destination. A portable record is provided to the patient to take to her next location. The Maternity Care Coordinator makes hospital visits to 80 percent of the patients who deliver in Johnston or Sampson County Hospitals. Other "extras" are also included to encourage participation in the perinatal program. At the 6-week visit, each baby has its picture taken and the family is given a copy of the photo. Photos are also displayed in the clinic. Layette packages, made up of donated baby clothes and supplies, are provided to all new mothers. The center also sponsors a car seat rental program which requires a $10 refundable deposit and charges a rental fee of only $5.00.

In addition to the obvious benefits to patients, the program also benefits the participating agencies. Neither Sampson nor Johnston county has bilingual/bicultural staff, and neither has the capability to provide psychosocial or support services to this population. Thus, Tri-County serves as a resource to the county health departments. Tri-County's physicians do not have obstetrical admitting privileges at the county hospitals. The coordination with the counties, through the perinatal care program, enables Tri-County to follow its patients through the postpartum period. The coordination provided by the perinatal care program permits all participating agencies to better achieve their goals of identifying needs, providing necessary services, and improving maternal and child health.

Costs/Financial Savings

The Baby Love program covers any services related to pregnancy. The first visit to the Maternity Care Coordinator is reimbursed at $50.00. Medicaid then pays $25.00 per month for each patient served. An activity form must be completed for each person in order to receive reimbursement. The $25.00 amount remains the same regardless of the number or extent of case management services provided during the month. While this is a potentially significant source of revenues, it amounts to less than $5,000 annually for the health center because most Tri-County patients do not meet the residency requirements for Medicaid eligibility.

Exhibit 1 shows the quantifiable resources used by the perinatal care program. A rough estimate of the total costs of this program is $118,600 (Exhibit 2). Theseresources are provided by federal grants (Section 329 end Comprehensive Perinatal Care), WIC, Baby Love, Johnston County Health Department, and Johnston County Department of Social Services. In addition, resources are provided by a number of colleges and

universities through student intern programs, and there are private donations of time and materials. Many resources provided by other agencies are an integral part of the provision of comprehensive perinatal care, but they are not part of the specific service coordination/case management studied at Tri-County. These costs are not shown in this analysis, but should not be overlooked in estimating the cost of perinatal care. They include the costs of obstetrical care at Sampson Memorial Hospital, Johnston Memorial Hospital, and North Carolina Memorial Hospital, and the cost of prenatal care services provided by Johnston County Health Department.

Lessons for Other Migrant Health Centers

The presence of a full-time Maternity Care Coordinator is important in establishing and maintaining working relationships with all of the agencies and providers involved in comprehensive perinatal care. The attitude of the Maternity Care Coordinator is a significant factor in the success of this program. She never loses sight of the fact that the point of this program is patient access. As a result, she makes it her business to get along with all types of people and work with all types of systems, not letting personal or professional rivalries get in the way. Tri-County has also learned that having certain support services on site, such as WIC, substance abuse counseling, Medicaid enrollment, and psychosocial services, greatly enhances the perinatal program. In addition, the attention to factors that increase patient comfort with the program has led to increased participation through word of mouth referrals. These factors include bilingual and culturally sensitive staff, extras such as baby photos and layettes, and transportation services.

Substance Abuse Program

Description

The substance abuse program at Tri-County is relatively young; it began in November 1939. In a very short time this program has grown to offer numerous services, including smoking cessation, alcohol, and other substance abuse programs. The Substance Abuse Coordinator at Tri-County has accomplished these tasks with a relatively small operating budget of about $65,000 in FY 1991, which covers a total migrant population in the Tri-County catchment area of approximately 13,000 farmworkers. The FY 1991 budget for this program included a one-time-only grant of $39,500 from the Office of Minority Health.

The Substance Abuse Coordinator has supervised Tri-County's substance abuse program for its entire life span. He and his staff have made great strides in creating a substance abuse program designed to do more than just treat the substance abuser. The substance abuse program uses an active and assertive approach to accomplish many goals which fit within three general classifications: counseling, education, and community involvement.

- Counseling. The Substance Abuse Coordinator conducts initial screening of farmworkers for substance abuse from referrals made by Tri-County medical staff. These initial sessions provide information which is used to decide if continued counseling at Tri-County or referral to a more appropriate in-patient or out-patient substance abuse program operating in Tri-County's catchment area is required. In addition, Tri-County medical records are annotated to indicate that a patient had a substance abuse counseling session, but details are kept in separate records for privacy. Tri-County medical and dental staff are thus alerted to a potential problem, but must contact substance abuse program staff if there is a need to coordinate patient management.

  The screening and counseling sessions also begin with the clients' education and awareness of substance abuse, services available at 'IX-County, and other substance abuse facilities available in the 'M-County catchment area.

  There is no reliable estimate of the amount of coverage Tri-County provides through its substance abuse program in relation to the total substance abuse services offered and utilization in the Tri-County catchment area.

- Education: Education is the major focus of grants made through the North Carolina Governor's Office. Funding through the Governor's Office calls for 70 percent of the funds to be used in educational areas. These funds are disbursed through the Governor's 30 percent Discretionary and High Risk Youth funds from the Drug-Free Schools and Communities Act of 1986.

  W-County provides educational materials and presentations to farmworkers, school children, community leaders, and growers on the problems and dangers associated with substance abuse. During the nine-month reporting period ending April 1991, 765 encounters with school children were accomplished. This function offers information and guidance concerning recognition and awareness of substance abuse problems to those who traditionally have tended to ignore these problems in the farmworker population. In addition, education at Tri-County encompasses primary care staff to refine and improve their skills at recognizing the signs of possible substance abuse among patients.

  Tri-County substance abuse educational efforts are estimated to cover nearly 100 percent of the migrant school children who participate in migrant school programs. The coverage is unknown for local seasonal and other farmworkers. Also, interns from the Center for Documentary Studies provide outreach, including some community education, to migrant camps in TM-County's catchment area.

- Community Involvement: The Substance Abuse Coordinator and Coalition Coordinator have worked hard to get the local community, especially growers, involved in the problems of substance abuse and how it affects the local community. Tri-County has an innovative outreach program called Farmers in Prevention (FIP) to enlist growers in the fight against substance abuse. This

one-time program was funded by the Office of Minority Health separate from substance abuse funding. During a six-month period ending May 1991, over 85 one-on-one meetings were held with community members to solicit support and involvement in FIB.

FIP also attempts to involve growers in the identification and referral of suspected substance abusers to appropriate programs. It is designed to educate growers about the collateral affect untreated substance abuse can have upon their farming operations. Involving growers as an integral part of substance abuse programs helps enlighten them as to the inter-relation of substance abuse and daily life, and builds support for publicizing the program and lay referrals.

Additional outreach conducted by 'W-County is designed for the general populace. In 'IX-County's catchment area, community education concerning prevention and improving early case findings and referrals to Tri-County or other substance abuse programs is provided by substance abuse program staff in coordination with schools, the media, governmental agencies, and volunteer organizations.

History

The substance abuse program grew from work done by the Substance Abuse Coordinator in his previous position with the East Cost Migrant Health Program. Tri-County hired him to launch a substance abuse program in November 1989. Since then he has obtained non-329 funding from the Migrant Benevolent Association to increase the scope of the substance abuse program. The substance abuse service started in November 1989 with a grant from the Governor's 30 percent Discretionary and High Risk Youth funds from the Drug-Free Schools and Communities Act of 1986.

The following barriers have been encountered in meeting the goals of the program:

- The counties are not very supportive of many migrant programs. Some providers in Sampson county have complained about seeing migrant patients. In addition, the Tri-County Medical Director does not have admitting privileges at the Sampson county hospital.
- Community involvement is very low, especially among growers, who are slow to accept that substance abuse is a community problem and not just an individual problem.
- Lack of continuity in funding. Funding is on a state and federal grant basis, and can be reduced or eliminated in times of budget constraints.
- Roviders must be certified substance abuse counselors to offer the complete Alcohol and Drug Education Traffic Schools (ADETS) program and classes.
- Transportation of farmworkers to substance abuse centers. Farmworkers often do not have private vehicles, and Hispanic workers are often leery of having

friends or spouses become aware of their seeking substance abuse treatment, so are reluctant to ask others to provide transportation.

- Psychological non-acceptance by individuals who have an abuse problem is especially acute within the Hispanic community. Cultural norms within the Hispanic migrant farmworker community tolerate large intakes of potentially addictive substances.

The following examples illustrate how these barriers were overcome:

- The Substance Abuse Coordinator and other personnel are working with the Sampson County Migrant Council to overcome the historical antipathy of residents toward migrant farmworkers in Sampson county.

- Tri-County's Medical Director obtained admitting privileges at a hospital in Smithfield, North Carolina, and maintains an affiliation with the University of North Carolina Medical Center in Chapel Hill.

- The FIP coalition was started to involve the local community in realization and awareness of substance abuse problems among farmworkers. The Coalition Coordinator holds FIP meetings with county Farm Bureau officials and other community leaders to promote FIP. The Center for Documentary Studies also provides two student interns for outreach.

- A grant was awarded from the Migrant Benevolent Association for continuing substance abuse work. This grant is for year-round outreach work to involve the community in substance abuse issues, allowing for continuity of services to seasonal farmworkers. In addition, qualification for farmworkers for Medicaid coverage is an on-going task to increase revenue sources.

- The program received a Governor's grant for substance abuse education programs.

- The Substance Abuse Coordinator is working on North Carolina state requirements to become a certified substance abuse counselor.

- The program provides transportation for farmworkers to substance abuse clinics and detox centers. 'IX-County purchased an automobile with a grant from the Migrant Benevolent Association to transport farmworkers. Also, the program coordinates transportation with a local church using the church's van.

- Continuing outreach and education programs are offered to enlighten farmworkers about problems associated with substance abuse and the availability of substance abuse services.

Operations

Tri-County's substance abuse program is an active program designed to screen and detect, educate, intervene, and prevent substance abuse in migrant and seasonal farmworkers in a three county area. The program involves a Substance Abuse Coordinator, Coalition Coordinator, aide, and part-time secretary. The aide is also responsible for the majority of transportation needs for farmworkers. Between July 1990 and March of 1991, the program documented 227 unduplicated first encounters and 765 prevention encounters in schools.

The primary difference between the 'migrant season" and operations during the remainder of the year is who Tri-County will see as a patient. Tri-County does not take new walk-in, non-fsrmworker patients during the migrant season. This will change somewhat when ADETS becomes a full-time program; ADETS is offered to anyone who has received a DWI citation in North Carolina. 'IX-County will principally offer ADETS in its catchment area of Johnston, Sampson and Harnett counties. Emphasis will be placed on farmworkers and those who speak Spanish as a native language.

Services provided by this program include:

- Smoking Cessation
- Alcohol Education
- Patient Screening and Referral
- Camp Outreach
- Prevention and Intervention (through education programs and materials and Farmers in Revention)

Coordination activities include:

- The Substance Abuse Coordinator gives individual and group smoking cessation counseling to migrant farmworkers. The Coordinator works with the American Red Cross for referral and inclusion of farmworkers in smoking cessation classes. He also provides bilingual smoking cessation classes unavailable directly through the Bed Cross.
- The Substance Abuse Coordinator coordinates with Alcoholics Anonymous (AA) and refers farmworkers to these programs when they are considered appropriate. He or his staff arrange transportation, if necessary, of farmworkers to AA meetings.
- Substance abuse program staff refer patients to regional m-patient and outpatient detox programs in the 'IX-County area. These programs include state and private non-profit programs. State rehabilitation programs take referrals after the patient has been through a detox program.

- 'IX-County offers a new service: Alcohol and Drug Education Traffic Schools (ADETS). ADETS provides education and instruction to Hispanic migrant farmworkers concerning North Carolina DWI laws. This is a formal program with Johnston county wherein Tri-County acts for the county in interfacing with Hispanic farmworkers. ADETS will be offered to farmworkers and other Spanish-speaking residents who have received a DWI conviction. The program includes: 1) Substance abuse assessment in Spanish, 2) Outreach to Hispanics convicted of DWI to assist them in meeting treatment requirements, 3) Providing Johnston County Clerk with instructions, written in Spanish, to be given to Hispanics convicted of DWI, 4) Roviding training for court interpreters concerning procedures to be followed to comply with court-ordered substance abuse assessments following conviction, and 5) Offering support in community efforts to establish AA and Narcotics Anonymous (NA) groups for chemically dependent Hispanics.

  The ADETS program has just started and will advance when the Substance Abuse Coordinator receives his certified substance abuse counselor designation.

- The substance abuse program coordinates with the Medical Director when the Medical Director or a physician suspects substance abuse. The program also coordinates with the Dental Director for oral cancer screening of patients with substance abuse problems.

  Patients who come to Tri-County for medical or dental visits and who evidence a history and/or symptoms of substance abuse are referred to substance abuse counselors before leaving the clinic.

- Tri-County hired a Coalition Coordinator to work on outreach through the Fanners in Revention (FIP) program sponsored by the Migrant Benevolent Association. The Coordinator meets with community leaders and growers to involve them in education and prevention. FIP tries to involve growers, crew leaders, and local community leaders in understanding how illegal sale and use of alcohol and drugs in migrant camps contribute to the substance abuse problem. The Coalition Coordinator writes monthly progress reports to the Substance Abuse Coordinator, who is the liaison with the Migrant Benevolent Association and reports on the program's success to the Association's Board of Directors.

- The substance abuse program provides educational materials and presentations at local schools. This aspect of T&County's substance abuse program is coordinated with school principals and administrators.

  Substance abuse treatment, prevention and referral are well integrated into the primary care clinics at Tri-County. Educational materials are located in the Tri-County clinic patient waiting area. These materials include written

pamphlets, and audiovisual tapes which can be viewed in the patient waiting lounge of Tri-County's primary care clinic.

- Clinic directors know of the availability of substance abuse counseling and refer patients for individual or group counseling sessions. In addition, physicians, dentists, nurses, and other clinical staff have participated in continuing education programs to improve skills in identification of substance abuse.

  Medical records are annotated for substance abuse; however, these records do not contain any detail for reasons of patient privacy.

- Adopt-a-Camp recreational programs, held every two weeks during the migrant season, are coordinated with community leaders and growers. This allows for outreach in a relaxed atmosphere.

Tri-County and Migrant Benevolent Association employees involved in this program include the Substance Abuse Coordinator, Coalition Development Coordinator, a part-time aide and driver, the Medical Director, and a staff dentist. Other agencies include county health officials and county migrant councils in Sampson, Johnston, and Harnett counties, the State Department of Health and Rehabilitation Programs, and the Migrant Benevolent Association, Inc. The Association is a major sponsor of T&County's substance programs, especially the PIP program.

Impact/Benefits

This program provides a number of benefits to the participating agencies:

- Increased awareness of substance abuse among seasonal and migrant farmworkers on the part of local county agencies.

- Increased utilization of services provided by Tri-County, which lessens the need for duplicate services by counties in the Tri-County catchment area. This translates into increased quantity and quality of services within the catchment area. This cross-utilization of services helps conserve fiscal resources of county governments, especially with recent budget constraints.

- Reduced destruction of public and private property caused by persons with substance abuse problems.

- Increased effectiveness of ADETS classes for DWI clients because program is offered in Spanish. Language barriers can cause additional problems unrelated to the cultural and social difficulties arising from the use of alcohol while driving a motor vehicle. In addition, coordination of services provides Spanish language information on substance abuse to county medical and social agencies.

- Enhancement of Tri-County's service capabilities and emphasis on prevention in accordance with BHCDA/HRSA funding guidelines.

- o Coordination with schools, social welfare programs, and other alcohol, drug, and mental health providers, assuring that other organizations can refer substance abuse patients to T&County when appropriate. This coordination also allows 'IX-County to refer patients for whom different levels or methods of substance counseling and/or treatment are considered appropriate.

Costs/Financial Savings

Exhibit 3 shows the quantifiable resources of the substance abuse program at Tri-County. Most of the funding is used for personnel. The Migrant Benevolent Association grant was from the federal Office of Minority Health for one year, so is no longer available. The major funding source for the program is the North Carolina Division of Mental Health, Development Disabilities and Substance Abuse Services, Community Based Programs.

There are a number of resources which are not quantifiable, but which are important to the substance abuse program. These include:

- o Smoking cessation classes.
- o Marketing and outreach costs to encourage substance abuse patients who are not coming to the clinic for primary care to seek treatment.
- o Referrals through the 'IX-County primary care clinic.
- o Service of regional detoxification centers.

The following are rough estimates of the costs attributable to some of these services which are not quantifiable in financial records:

Cost to county social and medical agencies who deal with migrant population (estimate uses Migrant Benevolent Association minority contract for one outreach worker and related costs times three counties in catchment area)	$150,000
Cost of educational programs in the local school systems by substance abuse counselors (estimate uses cost of part-time aide who is responsible for current school program plus related supplies and transportation times three counties in catchment area)	$38,500
Salaries of community leaders who interact with FIP program to reach growers ("guesstimate" for one person for each county times three counties in catchment area)	$90,000
Cost of growers to participate in FIP ("guesstimate" for two growers in each of three counties in catchment area)	$150,000

If the services of the substance abuse program were provided privately, it is estimated that local fees based upon the charges for similar services in rural settings would be between $35.06 and $75.00 per visit. In-patient detoxification centers charge $200.00 per day for routine care plus professional fees for a counselor and/or physician. In comparison, it is estimated that the cost of one-to-one counseling sessions provided by the substance abuse counselor at Tri-County would be $13.76 per encounter (the counselor estimates that 40 percent of his time is spent in counseling sessions). The same services provided by a Tri-County physician would cost $35.61 per encounter.

Lessons for Other Migrant Health Centers

Both the perinatal and substance abuse programs examined at this site visit reflect assertive and energetic program development. The perinatal program is structured around a solid comprehensive model that assures 100 percent case management to the center's obstetrical patients. The alcohol and substance abuse model is building direct relationships with all clinical services as well as developing an infrastructure within the Tri-County catchment area. At this point it appears that Tri-County should be commended for being able to maximize relationships in both Johnston and Sampson counties, the two counties that appear most cooperative, despite the fact that all three counties in the catchment area were significantly reluctant to assist in migrant health issues.

In both coordinated programs, the clinic has taken a holistic approach and has attempted to extend relationships beyond traditional clinical lines. For example, the substance abuse program has contracted to provide education for drivers who have been convicted of DWI citations, the perinatal program has engendered relationships with organizations and shelters for battered women, and both programs have done an excellent job extending into the religious community and utilizing churches, church congregations, and a variety of church resources in the area. In particular the development of community coalitions, specifically the Farmers In Prevention segment of the substance abuse program, is a model for developing community coalitions and attempting to develop grower and agribusiness cooperation on issues relevant to migrant health.

Finally, the clinic is to be commended for its excellent relationship with and mutual support of the Migrant Benevolent Association. The Association represents a community grassroots approach to assisting community health centers' efforts on behalf of the underserved. All of the positive successes to date in both integrated programs as well as clinic operations as a whole are likely to be extended by the recent commitment of the clinic and its board of directors to a strategic planning process.

Recommendations

The site visit team made several observations which were thought beneficial for extending and refining the interagency efforts of TX-County. For example, while the prenatal coordination of obstetrical patients is well done, with great attention to detail,

no firm protocols exist for areas such as hospital follow-up, flow charts of responsibility, home visits, or tracking migrant women back to homebase sites for follow-up care. While there have not been any problems, and do not appear to be any coordination problems in any of these or other areas of the perinatal program, it certainly would be to the benefit of the organization to develop formal written protocols to assure continuity should the program be able to expand and add staff, or should there be staff turnover.

While the substance abuse program is finally starting to achieve some degree of maturity and recognition in the catchment area, there are some areas of caution. For example, there have to date been no quality assurance efforts conducted on any of the substance abuse efforts with clinic patients screening and follow-up, or with patients referred from any other outside agency. In addition, the substance abuse program, for political reasons as well as for survival, has established quite a diversified set of services and it might be helpful to evaluate the continuity of services and follow-up with clients that has been achieved to date.

While elements of both the perinatal and the substance programs include formal agreements between agencies, overall many of the aspects of the program are not described by either formal or informal written agreements. The Program Directors end the Executive Director are urged to look more closely at many elements of the interagency collaboration and coordination, and to at least minimally document those efforts through letters of summary agreement sent by Tri-County to all participating organizations. While these letters do not have to reflect legal contracts, they would be an appropriate effort for Tri-County to begin more formalized tracking and documentation of those arrangements for future development.

The migrant coordinating councils in Sampson and Johnston counties have not had a distinguished performance record. Now that the Sampson county council is meeting again, it appears that TX-County might more assertively push for that council's backing and further support, refining and developing interagency and coordinated relationships on behalf of a variety of migrant services. Current activities of the council appear to encompass nothing more than reporting of anecdotal history from month to month, whereas it might be helpful for the council to identify a focused strategic issue (e.g., transportation, mental health) and to rally around that central focus for a period of months to achieve some sort of success. In Johnston county, where the migrant coordinating council has apparently not met for a substantial period of time, it really would be to Tri-County's benefit to serve as a lead in re-invigorating and leading coordinating council effort. In both counties, due to the limited responsiveness of the formal authorities on behalf of migrant health issues, these two coordinating councils could provide significant leverage on behalf of Tri-County efforts.

The Tri-County Newsletter, which is sent to many leaders in all of the catchment area, should take a more aggressive role in celebrating its interagency relationships and highlighting them as success stories and models. Such articles have the potential for enticing additional cooperation and collaboration. Along a similar line, Tri-County might look at getting some larger regional, state, or national recognition for some of

its efforts and programs (e.g., the PIP program and some of its work in educating drivers convicted of DWI related to the substance abuse program). This publicity could serve to further enable Tri-County to solicit and generate funding, and certainly to engender local support. In the 'IX-County relationship with Harnett county, where Tri-County provides direct reimbursement for some services to migrant farmworkers, the clinic should more thoroughly document and alert county commissioners to their contribution *on* behalf of residents. It appears that 'E-County may not receive appropriate credit for its contribution and effort which, in fact, essentially substitutes for support the county should reasonably be expected to provide in the first place.

Exhibit 1

Tri-County Community Health Center
Perinatal Program: Integrated Services Resources

Resource Category	Tri-County	Baby Love Medicaid	Universities	Johnston Co. DSS
Personnel				
Maternity Care Coordinator	1 FTE			
Driver/Health Aide	1 FTE	Pays $50 1st visit, then $25/patient/mo.		
Nutritionist	.25 FTE			
WIC Clerk	.50 FTE			
Physician	1 S hrs/week (40% time)			
Nurse Practitioner	4 hrs/week (10% time)			
Administrative Support	5 hrs/month (3% time)			
Students			4 @ 3 mo. each	
Eligibility Worker				10% time
Materials and Supplies				
Van-repairs and maintenance	$ 500/year			
Van-gas	$ 250/month			
Van-Insurance	$ 1,200/year			
Layettes	Donated			
Other supplies	See Budget			
Other Direct				
Liability Insurance				
Payment for Medicaid Denials	$2,500			
Student housino and transportation	Estimate			

Other Resources Not Shown/Quantified:

- Migrant Benevolent Association-funded program in first year through a grant of $129,000 from the Reynolds Foundation.
- Deliveries provided by Johnston Memorial Hospital.
- Medical prenatal care and deliveries provided by Sampson County Health Department and Sampson Memorial Hospital.
- Prenatal care and delivery for high-risk patients provided by North Carolina Memorial Hospital.

Exhibit 2

Tri-County Community Health Center Perinatal Program: Integrated Services Costs

Resource Category	Tri-County	Baby Love Medicaid	Universities	Johnston Co. DSS	TOTAL
Personnel					
Maternity Care Coordinator	$18,734				$ 18,734
Driver/Health Aide	$ 16.380				$ 16,380
Nutritionist	$ 7,008				$ 7,008
WIC Clerk	$ 8,857				$ 8,857
Physician	$ 22,800				$ 22,800
Nurse Practitioner	$ 3,000				$ 3,000
Administrative Support	$ 600				$ 600
Fringe Benefits (20%)	$ 15,436				$ 15,436
Eligibility Worker (2)				$ 1,700	$ 1,700
Student Interns			$ 4.000		$ 4,000
TOTAL PERSONNEL	$ 92,615	$ 0	$ 4,000	$ 1,700	$ 98,315
Other Direct					
Educational Materials	$ 1,200				$ 1,000
Van-repairs and maintenance	$ 500				$ 500
Van-gas	$ 3,000				$ 3,000
Layettes (4)	$ 1,000				$ 1:ooo
Van-insurance	$ 1,200				$ 1,200
Liability Insurance		$ 6,500			$ 6,500
Payment for Medicaid Denials	$ 2,500				$ 2,500
Travel	$ 1,500				$ 1,500
Training	$ 700				$ 700
Student housing & transportation (5)	$ 1,000				$ 1,000
Telephone	$ 957				$ 957
Utilities	$254				$ 254
TOTAL	$ 106.426	$ 6,500	$ 4,000	$ 1,700	$ 118,626

.) Source: 91/92 budget detail, Tri-C unty Commun ty Health Center.
(2!) Estimated at 10% of $17,000 annual salary.
i) 4 summer interns; estimated stipend from school of $1,000 each.
(4) Donated—estimated at $10/layette and 100/year.
(6) Estimated for 4 students, 3 months each.

Exhibit 3

Tri-County Community Health Center
Substance Abuse Program: Direct Program Costs

Resource Category	MBA (1) Minority Health	NC Mental Health	Church Van	Interns	TOTAL
Personnel					
Counselor (2)	$ 22,000	$ 26,250	$ 0	$ 4.000	$ 52,250
Aide (.5)	$ 0	$ 7,500	$ 1,300	$ 0	$ 8,800
Secretary (.5)	$	$ 6,250	$ 0	$ 0	$ 6,250
Fringe Benefits	$ 4,000	$ 8,000	$ 260	$800	$ 13,060
TOTAL PERSONNEL	$ 26,000	$ 48:ooo	$ 1,560	$ 4,800	$ 80,360
Other Direct					
Materials and supplies	$ 1,000	$ 4,600	$ 0	$ 0	$ 5,600
FIP	$ 0	$ 2,800	$ 0	$ 0	$ 2,800
Contractual/Training	$ 2,000	$ 4,000	$ 0	$ 0	$ 6,000
Travel	$ 3,600	$ 2,600	$ 2,000	$ 0	$ 8,200
Space	$ 00	$ 0	$ 0	$ 0	$ 0
Equipment	$4,583 (2)	$ 1,000	$ 0	$ 0	$ 5,583
Indirect					
Administration	$ 0	$ 2,000	$ 0	$ 0	$ 2,000
Overhead	$ 2,370	$ 0	$ 0	$ 0	$ 2,370
TOTAL COSTS	$ 39,553	$ 65,000	$ 3.560	$ 4,800	$ 112.913

.) This was a one-time-only grant. These funds are not available in FY 1992.

(2) Grant included 811,348 automobile purchase cost for transportation. 3-year depreciation = $3,783.

Yakima Valley Farmworkers Clinic
Toppenish, Washington

Summary

The Yakima Valley Farmworkers Clinic (YVFC), with headquarters in Toppenish, Washington, is a multi-specialty medical-dental health system with six medical-dental satellite clinics and one mental health satellite clinic serving the central lower Yakima Valley in Washington and two north central counties in the state of Oregon. This community/migrant health center has successfully established a broad-based medical and mental health system with services targeted primarily to children. The site visit exsmined the mental health services program, specifically the interagency agreements and relationships with the county, state, and school systems in Yakima county. The coordinated activities reviewed include service arrangements on campus at several school districts, a free-standing mental health clinic in Yakima serving community children by self-referral and agency referral, and a free-standing adult mental health counseling center in Toppenish. These activities and services have required the development of interagency collaboration with the Yakima' County Department of Mental Health Services, several school systems, the Washington State Department of Children and Family Services, and various informal relationships with other social services, court systems and private provider referral sources.

The financial scope of this particular mental health program approaches $900,000 in state and county grants, $2 million in gross charges with approximately $1 million in collected patient fees. The ability of YVFC to obtain these grants and develop these systems has provided an access pathway to mental health services for migrant fsrmworkers that otherwise would not have been available in their catchment area. YVFC has been able to develop this system based upon its longstanding community credibility for high quality medical and dental services. Of particular importance to its success are the culturally relevant system of care and the ability to be flexible and responsive to agency requests for adaptation and development of services. In all cases during the site visit, community agency representatives provided distinct testimony about the credibility, quality of services, and responsiveness of YVFC as key elements in their longstanding and maturing relationship.

Background

The Yakima Valley Farmworkers Clinic opened in 1978 as a result of a successful application to the U.S. Department of Health and Human Services requesting funding assistance for a community clinic. The community-based group initiating the request consisted of physicians and community members, some of whom remain as current employees and board members of the clinic. By mid-1980, the clinic had a budget of $3.5 million with approximately 100 employees. By 1991, the clinic consisted of six medical-dental clinics, one mental health center, a community education and counseling services center based at the Toppenish clinic, and an energy services and

weatherization assistance center in Toppenish. The current operating budget approaches $15 million, with the clinic system providing services to over 45,000 patients.

The clinic sites in the catchment area range from south central Washington State and the Yakima county region, south through the Yakima Valley into two north central Oregon counties. While the demographics vary somewhat from clinic to clinic through the catchment area, the patient mix is roughly 60 percent Hispanic, 20 percent Native American, with 20 percent of the patient population consisting of White and Black patients. Community-wide statistics indicate that 24 percent of the community served is under the poverty level; 15 percent is within 100-200 percent of poverty level; and 61 percent is over 200 percent of poverty level. Migrant and seasonal farmworkers comprise approximately 15 percent of the population in the catchment area, while they comprise about 67 percent of the current users of YVFC.

Organization and Staffing

As a community-based, not-for-profit corporation, YVFC is governed by a 13-member community board. Reporting to the board is an Executive Director, with six program and service directors reporting to the Executive Director. The Medical Director, Mental Health Clinical Director, Controller, Personnel Director, Pharmacy Director, and Director of Mental Health Services report to the Executive Director.

The Medical Mental Health Services Division is managed by a psychiatrist Clinical Director and a Mental Health Services Director. A Business Manager and several Program Directors for specific programs report directly to the Mental Health Services Director. Each mental health service program essentially has a separate Program Coordinator functioning as a department within the division. This structure provides for focused yet decentralized management of those services. The psychiatrist serves as Clinical Director for all of the mental health program services. Staff of the program consist primarily of masters-prepared professionals at the program manager level, with masters- and bachelors-prepared professionals and education counseling psychologists and social workers as staff in all of the programs.

YVFC mental health services are delivered through service centers based at four different sites. The Mental Health Services office is based in Yakima, and serves children through 17 years of age who may be suffering from social and emotional problems affecting their school or home life. Referrals to this program include family, self, medical, housing authority, school, justice system, and the Department of Social and Health Services Child and Family Services Division.

The school-based state treatment program, based in Toppenish, is located on the grounds of the Toppenish school system but serves five different surrounding school systems from as far away as 20 miles. This program serves emotionally and socially disturbed children and their families through a structured therapeutic classroom setting and an intensive case management service system. All the children in this program are identified and referred by school system staff and must meet identified criteria for special education behavioral problems. An additional school system, based

in the Selah School District, provides a similar on-site day treatment behavioral disorder services program. The Selah school system, located just north of Yakima, developed an individual district start-up plan for convenience and continuity of care.

A fourth principal delivery site for medical mental health services is El Centro de Amistad in Toppenish. The El Centro program targets adult Hispanic patients. El Centro provides counseling, therapy, traditional healing, and referral services adapted specifically to the Spanish-speaking adult population in the community. These services are provided in a home-like setting in a refurbished house in the community, less than one mile from the medical clinic in Toppenish.

An additional mental health services program is based in the Yakima Mental Health Office. This program, known as the Children's Hospital Alternative Rogram, arranges therapeutic foster home placement for children who might otherwise require institutionalization. The children in this program are within the purview of the Stats Department of Children and Family Services, and are state dependents.

Arrangements for services and integration and coordination of programs for all of these clients are managed through a comprehensive set of arrangements with Yakima county, other mental health care providers, YVFC, all school systems in the catchment areas, the Academy of State Child and Social Services, and the juvenile justice system. While these arrangements provide substantial access to mental health, prognosis, stabilization, and therapy in some areas, the entire region suffers from a lack of mental health providers willing to accept Medicaid assignment.

Children Family Case Management Program

Description

The Children Family Case Management Program of the Yakima Mental Health Service Office is funded primarily through the county Community Services Office.

History

This program began in 1980 when Yakima county approached YVFC, proposing to develop a mental health component to its system. The Yakima County Director of Community Services spearheaded this move based primarily upon his dissatisfaction with the local mental health community's inability to meet the needs of children and baaed upon the credible community reputation of YVFC. In addition, he indicates that there is a significant advantage to be gamed by having the medical clinic services as a screening and referral base in support of the child-based mental health services program. The primary barriers to the development of this system were faced by the county in deciding to pull funding from other community resources and centralize that funding in a contract with YVFC. The County Director of Community Services indicates that he was only able to make this move to improve the scope of and access

to services because YVFC had a solid and credible administrative structure and fiscal history, a comprehensive medical staff and services system, and a board with good community representation.

Operations

The children's case management program targets a total client case load of 109 children. It is an out-patient, short-term based stabilization and therapy program, accepting approximately 15 referrals a week. Referrals originate from school systems, the juvenile justice system, the Department of Social and Health Services, the Housing Authority, the clinic, and other medical and family referrals from the community. The three primary diagnoses for referral include conduct disorder, post-traumatic stress disorder (primarily abuse and neglect issues), and attention deficit problems. Case management includes therapeutic stabilization, medical referral, educational system referral, and occasional therapy referral. Although the operations, services, and quality of the program are praised by the County Director of Community Services, he is concerned that the county and the program itself are unable to provide greater access to in-patient beds for children with mental health problems and greater access for individuals with chemical dependency problems.

Impact/Benefits

The primary benefits of this program include a centralized program providing 24-hour emergency services with highly trained professionals, a medical model referral and backup system through YVFC, and a program specifically targeted to provide for mental health access for Hispanic and other minority populations traditionally not served by other mental health resources in this catchment area. Other benefits of this program include the $1 million provided directly to the clinic system by the county for services, which assists with overhead and further integration of mental health and medical needs for the user population. In addition, this particular program and relationship with Yakima county has positioned YVFC within the state and the catchment area to extend the credibility and community oriented health care leadership of the entire clinic system. While this program specifically benefits Hispanics' and other minorities' access to mental health services, it particularly provides access for migrant and seasonal farmworker children to a program and services to which they would otherwise not have access. An estimated 25 percent of the children served through this case management program are from farmworker families. Additionally, this Yakima county program provides a core of activities whereby other school systems and the county and community are able to benefit and extend their own mental health services programs.

School-Based Day Treatment Programs

Description

The school-based day treatment program, out of the Toppenish school district, provides services for eight other school districts. These programs target emotionally and socially disturbed children in a classroom setting primarily in the elementary grades. This program has evolved since 1980 when the school system originally engaged in the joint project with YVFC to provide some counseling to emotionally disturbed children. To be specifically eligible for this program, students must meet special education criteria for behavioral disorders. Within the school district and the education system catchment areas, approximately 60 percent of the students are Hispanic, 20 percent are Native American, and 20 percent are other minorities. Eighty percent of the school population is eligible for the free lunch program.

History

Since starting out in the 1980s in the Toppenish school system only, this program has expanded to include eight other district educational services, with children bused into the Toppenish site for classroom and case management therapy. While the program started very locally and specifically, it has now expanded regionally and changed each year in terms of expanded services and subcontracting relationships to YVFC. While the program currently targets children in the elementary grades, it has developed an expansion plan for preschool and middle school students.

The Special Education Coordinator for the Toppenish School District and Coordinator for this program with YVFC, indicates that the relationship has worked very well primarily because of YVFC's credibility within the community, capacity to deal with end understand the Hispanic community, and interest in expanding to meet unmet needs in the catchment area. Very importantly, the Coordinator indicates that the clinic's willingness and flexibility to work with the Toppenish school system in adjusting and developing the program as it has grown has been critical to the long-term relationship.

The intervention services program of YVFC and the Selah School District is targeted to provide case management counseling and therapy within a classroom setting for behaviorally disordered children. The program just began in December 1990, and originated based upon the credibility and reputation developed by YVFC and its prior relationships in mental health with students in the Toppenish school system. This state treatment classroom program is specifically targeted to seriously behaviorally disabled children and their families, and is currently designed to handle less than 10 children per year.

The Director of Special Programs for the Selah School District indicates that, in addition to the credibility and track record of YVFC, he has been particularly impressed with its flexibility in adaptation of the program for his school system's needs.

In particular, the school system found that it was not equipped to deal with the family issues required to handle the behaviorally disabled children in the program. The Director specifically indicates that YVFC's commitment to family outreach and its long-term history of outreach activities was what committed the school system to this contract.

Operations

The operations of this program are fairly straightforward. The school system personnel, from any of the schools represented, identify the special education behavior and qualifications of the students for referral to this program. Based upon school referral as a special education behavioral problem, the mental health treatment program engages in a client assessment with the school system. Based upon a qualifying assessment and availability of resources the student is accepted into the program. Each student has an individualized treatment plan developed. This treatment plan traditionally includes one-half day in a special education classroom with an additional half day in therapeutic interventions with the program staff. Children in this program are fully case managed, with family therapy included as necessary. Home visits and therapy are also included as required in support of the student's treatment plan. Other specialized needs of the students are referred to specialty services (e.g., medical needs will be referred to YVFC, drug and alcohol specific needs would be referred to specific community programs).

The Selah School does not serve a large percentage of migrant farmworkers (en estimated 4 percent of total enrollment is migrant and seasonal farmworker children). Although no migrant farmworker children have yet been served by the program, it certainly provides access should any of those children qualify for such services.

Impact/Benefits

The impact and benefits of this service to the migrant and seasonal farmworker family include access to specialized classroom treatments and services that otherwise might not be available. In addition, this relationship provides the farmworkers clinic with a direct relationship for medical referral with all of the participating school systems. The farmworkers clinic has found that many times the first access point for the family of the student in one of the treatment programs is through the school system contact. Estimates are that of all the children included in the school-based state treatment program, approximately 30 percent are children from farmworker families.

El Centro de Amistad

Description

El Centro de An&ad is the YVFC mental health center for adults based in Toppenish, Washington, less than one mile from the health center site. The site provides mental health and social services counseling primarily targeted to the Hispanic population, although a small number of Native American, Spanish-speaking patients are also served. The clinic has been in operation for seven years, with start-up funding coming from a culturally relevant grant start-up project from the State of Washington, additional monies from Title 19 state Medicaid billings, and a small amount of financial support from Yakima county.

This center provides a wide range of mental health counseling and therapeutic services to its patient population. The patient population is referred through YVFC, the Departments of Social Services in the county and state, other providers in the catchment area, and by self-referral. In addition to providing traditional therapies and counseling, El Centro also provides culturally relevant traditional healing and referral services for the Hispanic community. This mental health center site is housed in a converted house providing treatment and counseling in a home-like setting.

Operations

While original start-up funding for this center has expired, YVFC has found it to be such a successful operation that the clinic continues to support its operation beyond the revenue provided by direct state Medicaid billings. While almost all of the other mental health services of YVFC are focused on youth and adolescent services, this program serves adults.

Impact/Benefits

El Centro provides a lone source of access for adult Hispanic men and women who need and seek mental health counseling. While El Centro is a successful operation, meeting an unmet need for the targeted population, its ongoing existence is continually threatened by lack of mental health resources for this population and by lack of recognition of the mental health needs within the migrant health services program nationally.

Other Coordinated Projects

Description

The Children's Hospitalization Alternative Program, otherwise known as CHAP, is a specialized therapeutic foster care program for children up to B-years-of-age requiring

placement in a qualified licensed foster home. The YVFC medical mental health services program is contracted by Yakima county to provide case management and mental health therapy for these children, who are referred directly by the Department of Children and Family Services. The capacity of this program is limited to 20 children. In addition to the baseline funding from Yakima County, funding support is also provided through reimbursement from the Department of Child and Family Services in the State of Washington and from Title 19 State of Washington Medicaid.

YVFC has also received a new three-year grant from the county to provide intensive case management for six to eight children in a pilot project for more difficult mental health cases. While this project is an extension of the broad-based children's case management services, it is focused and targeted in terms of more complicated and intensive case management needs of children identified by county resources. This is a brand new program targeted solely to Hispanic and Native American children. While there is no way to project the potential for involvement of migrant children, the program is certainly available for their access should they qualify for the level of services.

Costs/Financial Savings

Exhibit 1 presents the costs of each coordinated activity by cost center and by expense category. Exhibit 2 shows the allocation of program resources to migrant farmworkers, and Exhibit 3 shows the allocation of salaries and benefits by cost center. The total expenses of these programs for migrant farmworkers and their families are almost $410,000, with 35 percent of these resources going toward case management, 29 percent for day treatment, 23 percent for CHAPS, and 13 percent for the El Centro program.

Lessons for Other Migrant Health Centers

YVFC has shown leadership and vision in risking entry into mental health services within its catchment area. The clinic has been receptive to and actively supportive of interagency and collaborative relationships among school systems, county and state agencies, and other private and public organizations within the area. Many of the programs have taken several years and much adjustment to develop to their current level of maturity. Achieving this level of integration has only happened because of the recognition by the administrative, clinical, and board leadership of YVFC that these efforts would provide access to services for their populations that was not otherwise available in the area.

YVFC has taken a diversified programmatic approach to community-oriented primary care. As importantly, it has taken a strategic business approach of being involved and involving the board in long range planning, sophisticated market analysis, solicitation of interagency and collaborative relationships, non-traditional services, and the management commitment to provide support and resources to sustain the program. All of these efforts as well as the overall planning and management of YVFC reflect a high level of business sophistication not commonly found in a not-for-profit organization.

YVFC has been able to develop interagency and collaborative relationships and an extensive mental health services program based upon long standing credibility in the community, specifically in service to Hispanic populations. In each interview with outside agencies involved as partners with YVFC, the agency representative indicated that the agency had sought out and welcomed participation with the clinic because of its long-standing financial stability, respect within the community, and commitment to the Hispanic population.

In each interview with the outside agencies, the agency representative made it very clear that one of the strengths of the on-going relationship with the clinic had to do with the clinic's ability and commitment to being responsive and flexible in meeting agency needs. Agency contact personnel indicated that YVFC listened closely to their needs, was willing and eager to make adjustments to meet those needs, and could be counted upon to be flexible in responding as those needs changed or other bureaucratic issues intervened in the relationship during the course of the contract relationship. This level of flexibility and responsiveness reflects the clinic's businesslike approach to the marketplace rather than a bureaucratic model.

The site visit team was particularly impressed with the high level of professional, self-assured, and knowledgeable staff providing services within the Medical Mental Health Services Division. In addition to the generally expected levels of cooperation, the staff was direct, candid, and more importantly, reflected a "big picture" understanding of the importance of their programs, a long range view of how those programs needed to mature, and the recognition of the importance of remaining flexible in their relationships with outside agencies and funding sources. In many similar not-for-profit settings, the site visit team has witnessed much complaining and hand-wringing over having to deal with county, state or other agency contracts. The professional staff of the YVFC Medical Mental Health Services appear proactive and mature in their recognition that they serve those agencies as customers, that service requires responsiveness, and that such responsiveness is critical to providing access to those services for farmworkers.

Interviews with the outside agency representatives indicated that they were highly satisfied with the quality of services being provided by YVFC and had a high level of confidence in the on-going capacity of the relationship as long as funding remained available. In all cases, agencies were confident that the quality assurance processes and/or licensing and review processes helped assure the highest level of service quality expected by the agency.

The site visit team reviewed most of the interagency and collaborative agreements and found that YVFC has a greater number of formalized written agreements with agencies than most other sites. These agreements reflect a mature, businesslike sophistication in attending to the key elements of contractual relationships. While the sophistication of these written agreements may reflect YVFC's long-term experience and history in developing these relationships, it remains exemplary as a standard toward which other centers should strive in pursuing interagency and collaborative arrangements.

Exhibit 1

Yakima Valley Farmworkers Clinic
Counseling & Residential Services
Income and Expense Statement

Resource Category	$	Percent	Day Treatment	El Centro	CHAPS	Case Mgmt.	nterventio n	Other Misc.
Percent total resources(1)		1.00	0.319	0.040	0.197	0.388	0.035	0.021
Percent migrant use (2)		N/A	0.33	0.50	0.25	0.33	0.00	0.00
Revenues(3)								
Patient Services	$52,414	0.038						
Title XIX	$ 467,289	0.337						
DCFS	$ 211,439	0.152	$ 211,439					
Case Management	$ 144,060	0.104				$ 144,060		
CDT	$ 125,150	0.090	$ 125,150					
CHAPS	$ 106,775	0.077			$106,775			
El Centro	$ 55,817	0.040		$ 55,817				
Other	$ 225,146	0.162					148.583	$29,150
Total Revenues	$ 1,388,090	1.000	$ 442,801	$ 55,817	$273,454	$ 538,579	$48,583	$29,150
Expenses								
Salaries	$ 629,494	0.477	164.437	$70,582	$ 143,927	$203,326	$98,348	$ 0
Fringe Benefits	$ 117.929	0.091	$31,286	$ 13.429	$ 27,383	$ 38,685	$ 18,712	$ 0
Other	[illegible]	0.083	$37.619	$4,742	$ 23,232	$ 45,756	$ 4,128	$ 2,477
Interco Mgmt. Fees	$ 117,459	0.082	$37,469	14,723	$ 23,139	$ 45,574	$4,111	$2,467
Foster Parents	$ 110,222	0.077	$ 0	$ 0	$110,222		$ 0	$ 0
Contract Services	$ 51,739	0.036	$ 16,505			$0	$ 1,811	$ 1,087
Supplies	$ 49,605	0.035	$ 15,824	$ 2,080	$$ 10,193 9,772	$$ 20,075 19,247	$ 1,736	$ 1,042
Space	$39,159	0.027	$ 12.492	$ 1,575	$ 7,714	$ 15,194	$ 1,371	$ 82i
Insurance	$37,359	0.026	$ 11,918	$1,502	$7,360	$ 14,495	$ 1,308	$ 78$
Bad Debts	$ 32,982	0.023	$10,521	$ 1,326	$ 6,497	$ 12,797	$ 1,154	$69:
Travel	$ 25,012	0.018	$ 7,979	$ 1,006	$ 4,927	$ 9,705	$ 875	$ 52$
Utilities & Telephone	$ 17,955	0.013	$ 5,728	$ 722	$ 3,527	$ 6,967	$628	$ 377
Depreciation	$ 16.621	0.012	5$ 3 0 2	$ 668	$ 3,274	$ 6,449	$ 582	$ 345
Total Expenses	$ 1.426.156	1.000	$ 192.642	$ 104,350	$381,179	$438,269	$134,764	$ 10,622
Net	($ 38.066)	-0.027	$250,159	($ 48,533)	($107,725)	$ 100,310	($ 86,181)	$ 18,528

(1) Percent of revenue resources per Controller, YVFC.

(2) Percent of migrant usage par individual area managers/directors.

(3) Identifiable revenues from grants are allocated to specific cost center. Remainder of cost center revenue is Title XIX, Patient Servicea, or Other revenue.

Exhibit 2

Yakima Valley Farmworkers Clinic
Counseling & Residential Services
Allocation of Expenses to Migrant Usage (1)

Resource Category	Day Treatment	El Centro	CHAPS	Case Mgmt.	ntervention	Other Misc.	Total
Expenses					$ 0		
Salaries	$ 54,264	$ 35,291	$35.982	$67,098	$ 0	$ 0	$ 192,634
Fringe Benefits	$ 10,324	$ 6,714	$ 6,846	$ 12,766		$ 0	$ 36,650
Other	$ 12,414	$ 2.371	$ 5,808	$ 15.100	$ 0	$ 0	$ 35,693
Interco Mgmt. Fees	$ 12,365	$ 0	$ 5,785	$ [illegible]	$ 0	$ 0	$ 35,551
foster Parents	$ 0	$ 1,040	$ 27,556	15,039	$ 0	$ 0	$ 27,556
Contract Services	$ 5,222	$ 997	$ 2,548	$ 6,625	$ 0	$ 0	$ 15,660
Supplies	$ 4,122		$ 2,443	$ 6,351	$ 0	$ 0	$15,014
Space	[illegible]	$ 787	$ 1,929	$ 5,014	$ 0	$ 0	$ 11,852
Insurance	$ 3,933	$ 751	$ 1,840	$ 4,783			$ 11,307
Bad Debts	$ 3,472	$ 503	$ 1,624	$ 4,223	$ 0	$ 0	S 9,983
Travel	S 2,633	$ 361	S $ 884	S 3,203	$ 0	$ 0	s 7,570
Utilities & Telephone	S 1,890		$ 819	s 2,299	$ 0	$ 0	s 5,434
Depreciation	s 1,750	s 334		S 2,128			s 5,031
Total Expenses	S 117,836	S 52,175	S 95,295	S 144.629	s o	s 0	s 409,935

(1) Percent of migrant usage per individual area managers/directors.

Exhibit 3

Yakima Valley Farmworkers Clinic
Counseling & Residential Services
Allocation of Salaries/Benefits by Cost Center (I)

Title	Day Treatment	El Centro	CHAPS	Case Mgmt.	Intervention	Other Misc.	Total
Accounting	$ 5,173	$ 5,173	$ 5,173	$ 5,173	$ 5,173	$ 0	$ 25,865
Billing	$ 2,657	$ 2,657	$ 2,657	$ 2,657	$ 2,657	$ 0	$ 13,283
Case Manager	$ 0	$ 0	$ 0	$ 17.240	$ 0	$ 0	$ 17,240
Case Manager	$ 0	$ 8,503	$ 0	$ 8,503	$ 0	$ 0	$ 17,007
Case Manager	$ 0	$ 0	$ 16,667	$ 0	$ 0	$ 0	$ 16,667
Case Manager	$ 0	$ 0	$ 0	$ 0	$ 18,726	$ 0	$ 18,726
Case Manager	$ 0	$ 0	$ 0	$ 17,562	$ 0	$ 0	$ 17,562
Case Manager	$ 0	$ 0	$ 0	$ 17,096	$ 0	$ 0	$ 17,096
Case Manager	$ 0	$ 0	$ 0	$ 21,715	$ 0	$ 0	$ 21,715
Case Manager	$ 0	$ 0	$ 0	$ 16.667	$ 0	$ 0	$ 16,667
CDT	$ 15,736	$ 0	$ 0	‘ s o	$ 0	$ 0	$ 15,736
CDT	$ 19,728	$ 0	$ 0	$ 0	$ 0	$ 0	$ 19,728
CHAPS	$ 0	$ 0	$ 16,613	$ 0	$ 0	$ 0	$ 16,613
Therapist	$ 0		$ 0	$ 15,575	$ 0	$ 0	$ 15,575
Counselor	$ 0	$ 14.3%	$ 0	$ 0	$ 0	$ 0	$ 14,340
Counselor, Supervisor	$ 14,116	$ 14,116	$ 0	$ 0	$ 0	$ 0	$ 28,232
FP - Coordinator	$ 0	$ 0	$ 15,736	$ 0	$ 0	$ 0	$ 15,736
Director	$ 5,693	$ 5,693	$ 5,693	$ 5,693	$ 5,693	$ 0	$ 28,464
Office Assistant	$ 2,657	$ 2,657	$ 2,657	$ 2,657	$ 2,657	$ 0	$ 13,283
Office Assistant	$ 2,506	$ 2,506	$ 2,506	$ 2,506	$ 2,506	$ 0	$ 12,531
Program Assistant	$ 0	$ 12,281	$ 0	$ 0	$ 0	$ 0	$ 12,281
Psychiatrist	$ 17,213	$ 0	$ 17,213	$ 17,213	$ 17,213	$ 0	$ 68,865
RN Supervisor	$ 0	$ 0	$ 0	$ 0	$ 22,342	$ 0	$ 22,342
Secretary	$ 2,657	$ 2,657	$ 2,657	$ 2,657	$ 2.657	$ 0	$ 13,283
Secretary	$ 13,319	$ 0	$ 0	$ 0	s o	$ 0	$ 13,319
Therapist	$ 20,355	$ 0	$ 0	$ 0	$ 0	$ 0	$ 20,355
Therapist	$ 0	s o	$ 17,508	$ 0	$ 0	$ 0	$ 17,508
Therapist	$ 0	$ 0	$ 18,940	$ 0	$ 0	$ 0	$ 18,940
Therapist	s o	$ 0	$ 19,907	$ 0	$ 0	$ 0	$ 19,907
Therapist	$ 0	$ 0	$ 0	$ 17,007	$ 0	$ 0	$ 17,007
Therapist	$ 21,321	$ 0	$ 0	$ 0	$ 0	$ 0	$ 21,321
Therapist	$ 0	$ 0	$ 0	$ 0	$ 18,726	$ 0	$ 18,726
Therapist	$ 0	$ 0	$ 0	$ 17,669	$ 0	$ 0	$ 17,669
Therapist	$ 0	$ 0	$ 0	$ 15,736	$ 0	$ 0	$ 15.736
Therapist	$ 21,306	$ 0	$ 0	s o	$ 0	$ 0	$ 21,306
TOTAL	$ 164.437	$ 70,582	$ 143,927	$ 203,326	$ 98,348	$ 0	$ 680,620
Fringe Benefits (2)	$ 31,286	$ 13,429	$ 27,383	$ 38,685	$ 18,712	$ 0	$ 129,494

:) Allocation based upon actual FTE and empoyee hourly rates applied t otal salaries paid in FY 391.
!) Rate of 19.0% applied to salaries and wages.

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Advisory Commission on Intergovernmental Relations. *Assisting the Homeless: State and Local Responses in an Em of Limited Resources.* Advisory Commission on Intergovernmental Relations, November 1933.

> This document is a compilation of fourteen papers from a March 1933 ACIR-sponsored conference on state and local responses to homelessness. The papers examine the characteristics and needs of the homeless population and the impact of housing costs, federal funding of intergovernmental programs under the 1987 McKinney Homeless Assistance Act, and additional federal, state, and local aid activities. Included are papers which present the results of coordinated programs for the homeless in Ohio and Wisconsin.

Advisory Commission on Intergovernmental Relations. *Intergovernmental Service Arrangements for Delivering Local Public Services: Update 1983.* Advisory Commission on Intergovernmental Relations, October 1985.

> This report examines intergovernmental arrangements for county and municipal service provision and transfers of services among state and local governments and private contractors during 1983, with trends from 1972. Data are from a summer 1983 mail questionnaire survey, conducted by ACIR and the International City Management Association, of over 2,000 city and county governments. Also included are data from a review of previous ACIR surveys and records and various private sources.
>
> The survey covered the characteristics of service arrangements, government officials' perceptions of institutional factors inhibiting arrangements, and the effects of arrangements on service delivery and costs. Services included police and fire protection, correctional institutions, public inspections, refuse collection, waste disposal, water supply, air pollution control, hospitals and other health facilities, selected welfare programs, public transportation, parks, libraries, museums, computer use, tax assessment, and billings. The report includes tables showing states with intergovernmental contract authority, intergovernmental service contracts and joint service agreements, cities and counties receiving state aid, and other survey results.

Aram, John A. and Stratton, William E. "Development of Interagency Cooperation." *Social* Service *Review* 48(3): 19'74, pp. 412-421.

> Successful interagency coordination in the health and social services area is an infrequent event, and documentation of successful efforts is even more rare. A successful planning effort involving 20 local agencies attempted to coordinate services to the aged in a public housing project. The significant factors in the origin of the cooperative activity and the aspects or factors in the planning process that contributed to the progress of the group are examined. Analysis of interviews with 31 persons involved in the planning suggests an initial "convergence of interests" as the initiating process of cooperation. A clear leadership structure in the group is inferred, and individuals perceived as key persons were found to see their agency goals as more immediate, more recent, and more numerous than others. Results pertaining to agency leadership are presented. The study indicates the dynamic quality of social processes involved in institutional change.

Association of Schools and Colleges of Optometry. Optometric Services *in Migrant Centers Demonstrated*. Washington, DC: Association of Schools and Colleges of Optometry, 1985.

> This news release describes a demonstration program conducted by the Association of Schools and Colleges of Optometry to provide optometric and other vision services to migrant workers and their families in California and Oregon. Projects were established at two migrant health centers and sponsored by the Southern California College of Optometry and the Pacific University College of Optometry. Additional projects were later developed in South Carolina, North Carolina, Texas, and Florida.
>
> The projects used supervising faculty and senior clinical year students from the universities to screen migrant children and adults and to provide primary and secondary care consisting of prescribed lenses and frames, vision training, and medical referral. Student evaluations of the clinical experience were extremely favorable, indicating that students were happy with the opportunity to be exposed to a different service mode, a different ethnic and cultural mix, and a variety of vision pathologies not otherwise seen in the normal educational setting.

Baldwin, D. "Providing Vision Services in the Saginaw Valley of Michigan." *Journal of Visual Impairment and Blindness* 80(8): October 1986, pp. 901-03.

> This article describes the Saginaw Valley (Michigan) Special Needs Clinic, which serves visually impaired children and adults, multiply impaired low vision persons, and developmentally disabled persona with vision problems. The program is baaed on a client-centered concept involving health professionals, rehabilitation specialism, special educators, consumers, and social agency personnel.

Benjamin, A. E.; et al. "Shifting Commitments to Long-Term Care: The Role of Coordination." *Gerontologist* 24(6): December 1984, pp. 598-603.

The authors surveyed state and local health planning agencies and Older Americans Act agencies, and found that coordination between aging and health planning agencies is directly associated with the level of attention given to long-term care priorities by the latter agencies. These findings suggest that coordination strategies may be important for policy change.

Briggs, Edna F. Long *Term Care Plan for Los Angeles County (California).* Doctoral dissertation. University of Southern California, 1989.

The long term care environment in Los Angeles County is characterized by a changing demography, increased consumer demand, multiple public and private service providers, quality and cost *concerns. The* purpose of this study was to develop a plan for a system of long term care based on immediacy and high need, comprehensiveness and viability. The study involved a search and synthesis of literature to define the system. Historical, descriptive, evaluative, statistical and judgmental data were collected and subjected to recognized procedures of external and internal criticism. Synthesis of long term care background issues, inter-organizational theory (organizations and the environment) and coordination theory provided a conceptual framework for the plan.

The model focuses on consideration for plan development/management, interdepartmental and interagency coordination, service coordination and delivery, and quality assurance as basic system elements. It is proffered that a system of long term care be developed through coordination, instead of integration. The Los Angeles County Area Agency on Aging is to assume the leadership role in the development and maintenance of such a system, due to its mandated and unique organizational characteristics. The plan will serve as a blueprint for initial and future action.

Camp, Robert C. *Benchmarking: The Search for Industry Best Practices That Lead to Superior Performance.* Robert C. Camp. Milwaukee: Quality Press, 1989.

Using a case history approach based on the distributive function, this book demonstrates how to conduct investigations to ensure that your industry is based on best practices.

Cárdenas, Dan. *Migrant Clinics' Access to a Computer-Based Patient Health Record.* Dan Cardenas. Austin, TX: National Migrant Referral Project, Inc., January 1980.

This program summary describes efforts to establish a computer-based system to store, retrieve, and transfer health records for individual migrant and seasonal farmworkers. Through an interagency agreement between the Migrant Education Program and the Migrant Health Program in the U.S. Department of Health, Education, and Welfare, migrant health centers have access to medical records for migrant children through the Migrant Student Record

Transfer System (MSRTS). The MSRTS network uses a network of terminals to maintain and transfer records between 15,006 school sites across the United States and Puerto Rico. Migrant health center participation was encouraged with the goal of making MSRTS a major depository of health records as well as education records for migrant children and, eventually, for adults. Such a system would make medical and dental records available in a central location to migrant health clinics along the migratory streams, allowing clinics to provide continuity of care across a broad geographical area. This summary sets forth specifications for a pilot project involving thirteen clinics.

Cárdenas, Dan. *PHS Indian Health Service and National Migrant Referral Project—Interagency Coordination: Position Paper.* Austin, TX: National Migrant Referral Project, 1976.

This position paper presents a rationale for coordination efforts between the Indian Health Service Division of the Public Health Service and the National Migrant Referral Project. The paper is meant to serve as a starting point for further, m-depth discussion of future coordination efforts. Suggested areas for collaboration include monitoring dental referrals, identifying existing or non-existing dental services in migrant stream, and assisting in workshop training.

Cárdenas, Gilbert. "Coordination in Human Resource Development Programs." Unpublished paper, undated.

This author discusses the concept of coordination as it relates to policy formation, administration, planning, and delivery of services in employment programs. Coordination is defined as the process of identifying common goals and objectives among various pieces of legislation and human resource development programs, and mixing and delivering services toward these common objectives without sacrificing individual program goals or requirements. Common barriers in administration, planning, and operation which inhibit program linkage and coordination are addressed. The paper traces the history of the current emphasis on program linkages in response to this nation's earlier piecemeal approach of recognizing and responding to specific problems as they arose, and looks at how excessive fragmentation is inefficient and denies many individuals access to the range of services available from different programs. Early manpower coordination approaches are described, and the effective utilization of advisory councils is suggested as the best means of developing a viable mechanism for coordination.

Carr, Carolyn Kehlor. *Analysis of Interagency Service to the Mentally Ill/Mentally Retarded Client in Missouri.* Doctoral dissertation. Central Missouri State University, 1988.

The problem of this study was four-fold: to determine 1) the extent to which the mentally ill and retarded client is served by the Missouri community mental health center system; 2) the extent to which budgetary issues influence this

service; 3) the extent to which other local community services work in concert to serve this group; and finally, 4) the extent to which the community mental health centers have a planned system of interagency cooperation to serve this population. The research method involved use of a field-tested survey form designed by the author. The survey was composed of 27 survey questions which centered around seven research questions. The survey was sent to all directors of the community mental health centers in Missouri. Eighteen centers responded to the survey. Because of the small sample, computation of percentages was the statistical measure used.

Carter, John D.; Cushman, Robert F.; and Harts, C.; eds. ***Handbook*** *of Joint Venturing.* Homewood, IL Dow Jones-Irwin, 1988.

This book contains a collection of articles on joint venturing strategies, legal and accounting considerations, U.S. anti-trust law, and tax aspects of foreign joint ventures. It reviews joint venturing trends end techniques in various industries including health, construction, real estate, information technology, **telecommu-**nications, manufacturing, banking and financial services, transportation, and waste disposal, as well as joint venturing in and between various areas and countries of the world.

Case, Lois Patterson. *Agency-Friendly: The Effects of* ***Type*** *of Interagency Relations on Influence and Funding.* Doctoral dissertation. The University of Texas at Arlington, 1988.

In recent years a growing number of funders have encouraged joint programs among two or more social service agencies. While such arrangements may appear to be cost-effective to the funders, there is some question as to whether they are beneficial to the collaborating agencies. If agencies are to participate in complex relationships, which are potentially conflicting and which threaten autonomy, there should be some offsetting benefits for them. This study examined the effects of various types of interagency relationships on the influence of agencies in the community and their success in obtaining future funding. The types and properties of the major models of **inter-organizational** relations were reviewed, with an emphasis on nonprofit social service agencies. Surveys were sent to the executive directors of 147 agencies in **Tarrant** County requesting information about their agencies, and asking them to rank other agencies for importance and influence. Information was also obtained from the local United Way con**cerning** allocations to member agencies. Predictors of agency influence were identified using path analysis, with numerous informal interactions having a stronger **effect than** formal programs. Some support was also found for the relationship between influence and success in obtaining funding.

Center for Systems Program Development. *Best Practices in Specialized and Human Services Transportation Coordination.* Washington, DC: Center for Systems Program Development, Inc., July 1989.

This document is the final report of a project funded by the U.S. Department of Transportation, Technology Sharing Program, and the U.S. Department of Health and Human Services. The project reports on arrangements for coordinating transportation and human services programs of state and local agencies during the period 1986-1989. Arrangements include agreements to coordinate schedules, share vehicles, centralize maintenance, or fully combine transit operations. Data are from private and public transportation providers, HHS, and state human services agencies. The report provides detailed case studies of exemplary programs providing or promoting coordinated transportation services to elderly, handicapped, or special users. Approaches described including providing services through a community action agency, a brokerage organization, a public county or regional paratransit system, a private nonprofit system, and a volunteer program. Four regional and state level coordination programs are also discussed in depth. All programs included have overcome at least two barriers to coordination. A compilation of federal funding programs that have a transportation component is included; it notes their authorizing legislation, activities, funding levels, and application procedures.

Center on Budget and Policy Priorities. 'Legislative Update." *WIC Newsletter* 9(9):3-4, December 11, 1989.

This article summarizes new provisions in the Budget Reconciliation Act of 1989 which affected maternal and child health programs. First, new Medicaid provisions expanded coverage for young children and required state Medicaid programs to provide for coordination between Medicaid and WIC. Programs would be required to notify eligible pregnant women and children of the available WIC benefits. The update suggests that local WIC programs should contact Medicaid offices and provide current, accurate information about WIC eligibility requirements and benefits.

In addition, the Act contained provisions which affected Maternal and Child Health (Title V) programs. The Department of Health and Human Services, in consultation with the Secretary of Agriculture, was directed to develop model applications to be used by pregnant women and children under age 6 to apply simultaneously for MCH block grant, Medicaid, WIC, Head Start, and migrant/community health center programs, as well as some programs for the homeless. The article summarizes these changes and briefly discusses their implications for WIC programs.

Coalition on Human Needs. How *the Poor Would Remedy Poverty.* Washington: Coalition on Human Needs, undated.

Under a grant from the Ford Foundation, the Coalition on Human Needs interviewed 202 low-income people across the country to learn about their experiences with employment, education, their families, and a wide range of government programs. Persons interviewed made wide use of the 15 cash benefit programs and 22 service-oriented programs about which they were questioned. However, no single program was considered a total solution for everyone or for any single family. Although respondents thought each program they had participated in was helpful, 29 percent suggested raising benefits;. 19 percent, loosening eligibility requirements; 15 percent, eliminating bureaucratic requirements; and 11 percent, improving the treatment they received from eligibility workers. The working poor were more likely than other groups of respondents to say that eligibility requirements should be loosened.

Virtually no program was immune from complaints about the bureaucracy entailed in qualifying and maintaining eligibility for cash benefits. This was particularly true, however, in the AFDC and food stamp programs. The amount of documentation required seemed excessive to many. Some people had to wait an entire day to see a caseworker, even though they had the requisite appointment. Respondents cited lack of knowledge about availability of emergency funds, and also suggested that welfare offices post information on job openings or other services that would be helpful.

Cohen, Larry and Taylor, Laurel. "Beyond Brochures: A Systematic Approach to Prevention." *American Journal of Public Health* 81(7): July 1991, pp. 929-930.

This article describes California's Contra Costa County Prevention Program which was designed to integrate and strengthen existing health promotion and disease prevention programs throughout the county, consolidate strategies, and conserve resources. The program fosters community coalitions. After coalitions are formed around specific objectives the program staff coordinates projects that make the best use of the knowledge and resources of all participating organizations.

Daniels, Marionette S. and Bosch, Samuel J. "School Health Planning: A Case for Interagency Collaboration." *Social Work in Health Care* 3(4): *Summer 1978,* pp. 457-467.

This article describes the process of a local collaborative planning effort carried out by representatives of New York City's Department of Health and Board of Education, with the Mount Sinai School of Medicine of City University of New York, in order to solve some of the problems that beset the school health care system for children in the East Harlem district of Manhattan. The origin and development of an interdisciplinary interagency team are described, and the

plan they ultimately produced is summarized. Behavioral issues encountered during the process are highlighted.

Dans, Peter E. and Johnson, Samuel. 'Politics in the Development of a Migrant Health Center: A Pilgrim's Rogress From Idealism to Ragmatism." New *England Journal of Medicine,* April 24, 1975, pp. 890-895.

This article provides a brief history of a migrant health clinic funded by a grant from the U.S. Department of Health, Education, and Welfare to the Foundation for Urban and Neighborhood Development in Colorado. First the article gives a brief history of the grant process, which was hotly contested by a number of competing projects. The narrative goes on to describe the process of setting up the clinic and hiring its operating staff.

Dans and Johnson also discuss "bridge-building" activities which took place once the clinic was operational. The clinic works closely with the local police department, school board, and county health department. These entities are able to resolve earlier difficulties and integrate their planning to prevent duplication of services.

The article specifically addresses the question of coordination among agencies during the funding process. It examines some of the problems which led to discord among the competing projects for the clinic's grant award, and stresses the large number of groups, including medical societies, county and state health departments, comprehensive health planning agencies, third party carriers, neighborhood and other consumer groups, and local, state, and federal elected officials, which expect to be involved in the award of a grant for health services to specific populations.

Dombroski, Patricia N. *Coordination with Migrant Health Centers.* Trenton, NJ: U.S. Dept. of Agriculture. Food and Nutrition Service. Mid-Atlantic Region, 1989.

The Department of Agriculture is involved in ongoing federal coordination efforts to better serve migrant farmworkers. The Migrant Health Program was encouraged to use the poster "Food for Health/Alimentos Saludables" in its migrant health centers to assist in referrals to WIC and CSFP. This memorandum encourages state agencies participating in the Supplemental Food Programs to order a supply of posters in order to aid in targeting efforts for reaching high-risk pregnant women. It also notes the purpose of migrant portable OB/prenatal medical records published by the National Migrant Resource Rogram and suggests that WIC and CSFP agencies might be interested in using them.

Donovan, Susan Ellen. Social *Policy and Young Children With Special Needs: Implementation in Maine (PL99-457).* Doctoral dissertation. Boston University, 1989.

The purpose of this research was to examine the relationship between policy and practice and the effect of changing attitudes on this relationship. The

formulation of social policy on the Federal level and its implementation at the state level were used to illustrate this interdependence. The process of compliance with P.L. 99-457 (the Education of the Handicapped Act Amendments of 1986) by an interagency collaborative in the state of Maine was the vehicle used for illustration. The study of P.L. 99-457 was used to examine the evolution of changing attitudes which resulted in the expansion of services for young children with special needs nationally.

An examination of the law itself, through document review and interviews was undertaken, following the progression from inception to passage and the development of regulations. A history of federal legislation affecting young children with special needs was also compiled. In the second component of the study, data was gathered and analyzed over a sixteen month period of observations of the Interdepartmental Coordinating Committee for Preschool Handicapped Children (ICCPHC). This committee is responsible for implementation of P.L. 99-457 in Maine. Six major policy areas inherent in the legislation (interagency collaboration, family support and involvement, funding, personnel development, data collection, and program standards for a comprehensive service delivery system) were identified and analyzed using an adaptation of Gallagher's model of policy implementation analysis. The process of the implementation of these six policy areas by ICCPHC was explored, examining the barriers to implementation which emanated from both ICCPHC and the federal government. Processes which facilitated implementation were alsoexamined.

Edgar, Eugene and Maddox, Mary. Single ***Portal Intake Project. Final Report 1980-1983.*** Seattle: Washington University, 1933.

A project is described to develop a model system by which local education agencies (LEAs) can form successful working relationships with other human service providers to better serve special education students. The models (both process and content) designate LEAs as the central access point to the service continuum. The project's efforts to devise procedures for interagency collaboration focused on strategies ("recipes") for specific problems. Strategies took the form of ecological experiments to determine which systems components affect the child and family. Accomplishments included development of a process to analyze federal, state, and local programs (such as P.L. 94-142, the Education for All Handicapped Children Act; Head Start; Medicaid; and Maternal and Child Health) and implementation of a Delphi needs assessment polling 80 special education directors and mid-management personnel to determine major issues affecting the delivery of special education and related services. A process model for identifying specific problems and solutions at the service delivery level was used to develop seven content models: (1) the Early Childhood Interagency Transition Model; (2) the Adult Transition Model: Planning for Postschool Services; (3) the Early and Periodic Screening, Diagnosis and Treatment Model; (4) the Mental Health/LEA Collaborative Model; (5) Concurrent Services Model; (6) the Special Education/Vocational Education Model; and (7) Juvenile Corrections Transitional Model.

Foster, Catherine Alter. 'Changing Structure of Elderly Service Delivery Systems." *Gerontologist* 28(1): February 1988, pp.9148

This study compared first- and second-generation inter-organizational service systems serving the elderly. The study found that integration of Medicaid programs with the Administration on Aging-funded system was changing the structure of community-based elderly services. The second-generation system served a larger volume of clients, being more centralized, differentiated, formalized, and smaller in size.

Gilson, George J. 'Birth on the Border: The Brownsville Community Health Center." *Health and Development,* Summer 1987, pp. 23-27.

This article describes a successful model for delivering prenatal and obstetrical services to high-risk mothers in an out-of-hospital birth center. The center uses certified nurse-midwives under the supervision of physicians to provide services for a large number of high-risk pregnancies, including problems related to poverty, long-term neglect of pre-existing medical problems, teenage and "over-age" pregnancies, women who have already had many babies, high rates of hypertension and diabetes, and late or no prenatal care. One key facet of the program's success is its cooperative efforts with local lay midwives and Mexican hospitals. Since lay midwives attend a significant number of births in the area, the center conducts continuing education courses for them every year to make them aware of high-risk conditions which should be transferred to a hospital and to teach the basics of infant resuscitation.

In addition, the center works to establish linkages with the Mexican rural indigent hospital in nearby Matamoros in order to create a referral system that will work smoothly, help train Mexican residents and medical students, and provide a 'safety valve" for health center patients who cannot obtain care in the U.S.

Goldman, Harvey and Intriligator, Barbara. 'Factors That Enhance Collaboration among Education, Health and Social Service Agencies." Paper presented at the Annual Meeting of the American Educational Research Association, Boston, Massachusetts, April 16-20, 1990.

In 1986, Congress passed Part H of P.L. 99-457 (the Education of the Handicapped Act) to address the educational, social, and health needs of handicapped and developmentally disabled infants and their families. Since this population's needs could not be addressed independently, each state was expected to develop collaborative organizational structures and processes through appointment of an Interagency Coordinating Council. Relatively autonomous state and local agencies were now being asked to become interdependent and establish ways to share or reallocate existing resources. The study summarized in this report examines the ability of state agencies to collaborate and factors contributing to interagency effectiveness. Over an l&month period, three interagency units

within a single state were examined: 1) the Interagency Coordinating Committee; 2) the Interagency Placement Committee (for coordinating placement of acutely disabled children); and 3) the Interagency Committee for Children with Special Needs. The interagency units were analyzed according to eight effectiveness factors: objectives, policies, structure, resources, loyalty, agreement, decision-making, and personnel roles. They were also ranked on a continuum of cooperation-coordination-collaboration. The first two units were judged as effectively collaborative; the third was considered dysfunctional. Findings show that collaboration is not always an appropriate interagency strategy. Other conclusions are discussed at length.

Gonzales, Jim L. Key *Issues in Achievement of Educational Continuity for Migrant Students.* Denver, CO: Education Commission of the States, 1981.

Educational effects of migrant student mobility are reviewed and issues and recommendations for educational continuity are offered for discussion by policy makers. Considerations for discussion of mobility are presented: continuity of age-grade level progression and education/social/he&h services; agency responsibility; communication requirements; uniformity of instruction; graduation requirements; assessment procedures; record-keeping; materials cross-match indexing; and coordination of instructional, counseling, and administrative components. Issues inhibiting educational continuity are identified: lack of integration of migrant educational services; need for bilingual instruction; ineffective parent advisory councils; lack of coordination among funding and service delivery agencies; problematic special education referrals; inadequate demographic data; interstate differences in competency testing and graduation requirements; inadequate records transfer; lack of communication among programs; and need for flexible programming, career guidance counseling, remedial classes, and uniform curriculum. Three recommendations call for research agenda developed by federal agencies to include needs studies, demographic data, migration patterns, nature of interschool communication, methods for meeting student needs; development of support services end remedial opportunities and innovative planning and administrative procedures; and a national interstate migrant student policy including uniform definitions of migrant students and reporting regulations, coordinated formulas for fund allocation, guides to agency and administrator responsibilities, and federal funding of program coordination and development.

Grantsmanship Center. 'Brother, Can You Spare a Coupon?" Myrna Oliver. The *Grantsmanship Center Whole Nonprofit Catalog,* Winter 1990, p. 4.

This article describes a cooperative community effort to provide meal coupons to people who beg in the streets of Los Angeles' Skid Bow. The program involves a number of nonprofit agencies and local businesses. The Weingart Center Association, which operates a job counseling, health care, and food program, was searching for a way to help the public feel good by handing out a free meal instead of money. The program helps panhandlers by assuring them a free

nutritious meal and motivating them to visit the *center,* where other help is available. It also helps the Weingart Center Cafe break even. The Center sells food coupons to downtown businesses for distribution to employees. Businesses which do not wish to distribute food coupons may donate funds raised by their employees. The donations are used to buy food coupons which are given to nonprofit service agencies. Other businesses pay for the coupons, then donate them back to the Weingart Center to be used for Center programs, the majority of which provide beds and counseling but no food.

Hadden, Susan G. 'Institutional Barriers to Risk Communication." *Risk-Analysis 9 (3):* September 1989, pp. 301-308.

It is now generally agreed that risk communication (RC) is more successful when experts engage in dialogue with citizens than when they use the kind of one-way presentation of scientific data, risk analysis, and risk comparison that has often characterized public hearings. Although dialogue may help to overcome citizens' difficulties in making decisions based on complex technical information, it is difficult to establish appropriate conditions for conducting such dialogue. Here, barriers to RC that arise as a result of institutional arrangements are considered, and illustrated with reference to experience in implementing the Emergency Planning and Community Right-to-Know Act of 1986, and to the results of several informal surveys of citizens and public officials implementing the law. Barriers that restrict citizens' access to information, data collection, availability of data analysis and interpretation, and interagency cooperation in government and industry are detailed. Overcoming these barriers requires alterations in the statute, development of appropriate institutions for citizen participation and mobilization, and more careful understanding by policy makers of the kinds of information citizens want and can use.

Haverstock, Mary Jo and Sullivan, Martha. "Rural Cooperation-A Beginning." *Focus On: Rural Programs.* Publisher not identified, undated.

Haberstock is Director of Chances and Changes, a domestic violence hotline and shelter in rural New York. Sullivan is Program Coordinator of the Batavia YWCA Domestic Violence Program in Genessee County, NY. This personal account very briefly describes how these two individuals and their respective programs work together to share experiences and knowledge, and to develop practical workable methods to achieve their common goals. Through the NYSCADV Rural Task Force, these and other programs share information on funding sources, volunteer training, and other program aspects.

Helms, David W.; Campion, Daniel M.; and Moscovice, Ira. *Delivering Essential Health Care Services in Rural Areas: An Analysis of Alternative Models.* Rockville, MD: Agency for Health Care Delivery and Research, 1991.

This report is a revised version of a background paper for a 1990 workshop 'Alternative Models for Delivering Essential Health Care Services in Rural

Areas." The analysis examines six models of the conversion of closed or failing rural hospitals into alternative kinds of health facilities in order to maintain essential health care services for rural residents. Three models maintain acute cars inpatient beds for stabilization and holding capacity; the other three models eliminate all acute care beds. Each model uses the same basic remedies to address these problems: reduce or eliminate inpatient beds, discontinue performing costly and complicated services, cross-train personnel to perform multiple tasks, and develop referral relationships and linkages with other hospitals.

Hoban, Thomas J. "Barriers to Interagency Cooperation." *Journal of Applied Sociology 4:* 1987, pp. 13-29.

The interagency network responsible for promoting soil conservation in the United States may not function as effectively as many observers think it should. Better cooperation is needed among United States Department of Agriculture (USDA) agencies to insure more widespread use of conservation. Cooperation among four USDA agencies involved with conservation in southwestern Iowa is examined. Barriers that may limit cooperation are examined with telephone interview data from four directors concerned with 63 agencies. The data include perceptions of the environmental (external) context, individual beliefs about working with other agencies, perceived interpersonal conflict, and distance between offices. Multiple-regression models are tested for frequency of three types of interagency cooperation with each of the agencies: client referral, informal interaction, and formal meetings.

Hodgkinson, Harold L. *Same Client: The Demographics of Education and Service Delivery Systems.* Washington, DC: Institute for Educational Leadership, 1989.

In the United States, services (such as education, health care, housing, and transportation) are provided for citizens by a bewildering array of agencies at many government levels. Service organizations must learn to communicate across functional lines, and educators must become familiar with other service providers at various levels. This means perceiving the client as the most important part of the organizations providing services to that person, family, or group. The rationale is that these agencies are all serving the same children and families as clients. This approach is the most efficient, effective, and humane way to deliver services in an era of diminishing financial resources. Drawing on numerous maps, tables, and statistics, this report explores the complex interrelationships among family demography, housing, transportation, health, crime, and education. Interagency cooperation and taxpayer investment in families' basic needs are essential to prevent future problems (like crime, illiteracy, mental retardation) and reduce the need for costly programs to deal with them. For example, it would be more cost-effective to help low-income families secure affordable housing and to supply small grants to cover broken down cars and medical emergencies than to maintain these same families on welfare. Prisons are another costly service that might be reduced by investing more heavily in early education and college access programs. Recent occupa-

tional and demographic trends (including metropolitan areas moving across state lines) are provided to support an interactive, client-centered agenda and recommendations for achieving it.

Housing Assistance Council. *After the Harvest: The Plight of Older Farmworkers.* Washington, DC: American Association of Retired Persons, 1987.

This report on older farmworkers focuses primarily on housing, but also discusses a wide range of issues concerning older workers. The report describes existing public and private programs and gives good examples of existing and planned models for cooperative housing efforts. Also included is an overview of the older farmworker population, with demographic estimates and other statistical data. Design features, including floor plans, for congregate housing for older farmworkers are discussed, and recommendations are made in the areas of public awareness, information to state and local policy makers, technical assistance, financial support, owner-occupied housing, conferences, and health care.

Hulme, Thomas S. and MacQueen, John C. *Networking through Regional Child Health Centers: An Alternative Delivery System.* Iowa City, IA: Iowa University, Iowa Mobile and Regional Child Health Specialty Clinics, 1986.

This report describes a regionalized system of community based child health centers developed in Iowa to provide coordinated secondary level health services for children with chronic illness and handicapping conditions. The system is based on two principles: (1) Communities will be given the responsibility for determining which health services are needed and for providing these child health services with state programs serving as the backup resource; (2) Community programs that provide child health services will function in close cooperation and collaboration with established community systems (medical care system, educational system and social services system) that provide other child services. Chapters of the report have the following titles: (1) Introduction; (2) Networking to Achieve Change; (3) Development of Regional Center Service System; (4) A Stratified System of Care; (5) Results: The Creation of a System of Services; (6) Data, Interpretation, and Evaluation; (7) Lessons and Conclusions; and (8) Future Directions, Questions and Issues. A 34-item bibliography is followed by an appendix containing such items as the inter-agency memorandum of understanding, an individual service plan summary, a health survey report, health services questionnaires, and evaluation data.

Iles, Paul and Auluck, Randhir. 'Team Building, Inter-Agency Team Development and Social Work Practice." *British Journal of Social Work* 20(2): April 1990, pp. 151-164.

This article presents team-building techniques in organizational development and discusses their applicability to social work practice. Issues of interagency collaboration are addressed, including problems of diverse structures, interest, constituencies, and power levels. A framework is presented for the development

of interagency and multi-disciplinary teams, illustrated by interventions with the East Dorset Community Drug Team and a nursing/social work staff team in a hospital maternity unit in England. The article concludes that social workers are the best-equipped professionals to promote team building, given their experience and training in liaison types of activities.

Institute of Medicine, National Academy of Science. *Health Services Integration: Lessons for the 1980s.* National Academy of Science, 1982.

This report is a three-volume set which describes past and current efforts toward service integration. The landmark study reviewed the literature and current programs; the migrant component was only a part of the whole study. The report concluded that it is the responsibility of governments to ensure that necessary services are available and accessible, regardless of whether or not patients are able to pay. To carry out this responsibility, the report recommends that "providers of last resort" be available to provide ambulatory, emergency, and hospital care to meet health care needs which are not otherwise met.

Interagency Migrant Services Committee. *Interagency Migrant Services Committee.* Memorandum, 1984.

This memorandum briefly lists the members and describes the Interagency Migrant Services Committee which was reconstituted by the Governor in 1976 to coordinate the delivery of services for migrant households and to serve as a clearinghouse for an exchange of views, problems and possible solutions between all concerned parties in the area of migratory farm labor.

Jelinek, Janis A.; et al. "Multilevel Collaboration for Improved Infant Services in Rural America." *Rural Special Education Quarterly* 7(1): 1986, pp. 3-6.

This article describes the Wyoming Infant Stimulation Program (WISP) and its numerous collaborative activities with federal, state, and local agencies, including the Agricultural Extension Service and maternal and child health programs. The article notes that successful collaboration was informal and involved cooperation on specific, discrete joint projects responding to immediate needs.

Kahn, Judith A. and Georgianna Larson. "Meeting Needs with Scarce Resources: Community Network Building for Low-Incidence Conditions." *Education and the Changing Rural Community: Anticipating the 21st Century. Proceedings* of the 1989 ACRES/NRSSC Symposium.

In October 1983 Pathfinder, an organization in Minneapolis, Minnesota, was awarded a federal grant to develop a community network model serving children with chronic health conditions and their families. This document describes the model, demonstrated at four sites in Minnesota and Wisconsin. The model is based on four key assumptions: 1) children with chronic health conditions and their families face a common set of problems, regardless of the specific disability; 2) services for these families can be improved by enhancing cooperation among

existing health, education, and community programs, rather than by creating new ones; 3) community network building can be best facilitated if the network is initiated at the community level; and 4) community network building for these children and their families will be most effective if the parents are involved in the planning and development of the network Phase one of the program involves formation of a local task force, catalyzed by the common perception of problems and a shared need to find solutions. The second phase is to determine needs of and resources for children with chronic health conditions. Phase three is the development and implementation of an action plan, setting goals and priorities before planning appropriate strategies. Such strategies include inter-agency cooperation, parent group development, educational programs, and resource development. The fourth phase is evaluation of the network. Successful collaboration is based on cooperative working relationships between individuals and agencies, a formal needs identification process, leadership development, and realistic funding.

Kovalick, Walter William Jr. *Improving Federal Interagency Coordination: A Model Based on Microlevel Interaction.* Doctoral dissertation. Virginia Polytechnic Institute and State University, 1988.

This dissertation proposes a model for federal interagency cooperation that moves beyond traditional inter-organizational coordination literature and exchange-based concepts of cooperation. Drawing from the principles of 'authentic management" founded in humanistic psychology and negotiation literature, it suggests that such inter-organizational cooperation is developed and nurtured at the micro level. Only through direct engagement of the principals can the interests of the parties be revealed and dealt with to completion. In addition, the dissertation recognizes the unique character of such engagement when it takes place in pursuit of the public interest, as opposed to more traditional private settings.

The dissertation examines this model in the context of the Interagency Regulatory Liaison Group (IRLG). The IRLG was formed by the chief executives of the five federal health and safety regulatory agencies in 1977. It operated for four years with their personal involvement and enthusiasm, until its charter expired in 1981. Involving hundreds of employees from the five agencies, it stands as a unique organizational experiment in cooperative activities. The study applies the IRLG experience, as seen through in-depth interviews with the agency heads and staff, to the micro-level model. The IRLG experience illustrated the model concepts of 'contactful" engagement and integrative bargaining at the federal interagency level. It showed the importance of the agential perspective on the part of the chief executives as they worked together on joint projects. It also illustrated the essentiality of building a common language for discussion and resolution of inter-organizational differences. Finally, the emphasis in the model on maintaining both the substantive and process aspects of on-going interagency coordination is shown in the IRLG.

LaCour, John A. "Interagency Agreement: A Rational Response to an Irrational System." ***Exceptional Children*** 49(3): November 1982, pp. 265-67.

To be effective, interagency agreements must overcome a variety of obstacles, including lack of coordination between state and local agencies. A process for overcoming those barriers includes identifying resources to be exchanged and teaching special education or mental health concepts to the other agency(ies). Useful agreements are written simply, systematically, and flexibly.

Larson, Oscar W. III. ***ESCAPE Project Performance Report for the 1984-85 and 1985-86 Periods.*** Ithaca, NY: Cornell University, Department of Human Development and Family Studies, 1987.

This report summarizes accomplishments of the ESCAPE (Eastern Stream Child Abuse Prevention and Education) Project over its final two years and identifies products developed under its auspices during this period. An introduction describes the project which was initiated in 1982 to establish and reduce the incidence of child maltreatment in the migrant population and operated through state and local education agencies in cooperation with health, legal services and law enforcement, job training and safety, child protection, human services, farmworker, family, and minority advocacy agencies. Project activities in research, training, technical assistance, preparing resource materials for educator and health personnel, and coordination of public and private efforts are summarized in separate sections. The bulk of the report consists of a series of eight attachments. They include texts of studies of incidence and patterns of migrant child maltreatment in Florida, Pennsylvania, New Jersey, and Texas, as well as selected segments of state migrant child abuse prevention plans for California, Florida, Illinois, Maryland, New Jersey, and Washington. Also included are materials developed for the National Migrant Child Abuse Prevention Institute and introductory pages of 'What's a Kid to Do about Child Abuse?' and What's a Teacher to Do? Child Abuse Education for the Classroom."

Lebowitz, Barry D.; et al. "Mental Health Center Services for the Elderly: The Impact of Coordination with Area Agencies on Aging.* ***Gerontologist*** 27(6): December 1987, pp. 699-702.

This article examined coordination between community mental health centers (CMHCs) and Area Agencies on Aging (AAAs) through a survey of 281 CMHCs. The authors found that affiliation with AAA was associated with more indirect services of all types, more sites where mental health programs were offered to the elderly, and more provision of direct services, such as Alzheimer's disease treatment, family support, and respite.

Leeds, Stephen; et al; eds. ***EPSDT: A How-To Guide for Educational Programs.*** Washington, DC: Health Care Financing Administration, U.S. Department of Health, Education and Welfare, 1979.

Intended primarily for state and local health and education staff, this guide considers using the school setting as one resource in the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program. Chapter I introduces the EPSDT program and describes its services to Medicaid eligible children. The chapter also sets forth school health goals as well as the health needs of the school aged child. The incidence of disabilities in this population is noted, and the intervention role of EPSDT emphasized. State operation and outreach activities are considered. Chapter II focuses on school roles in EPSDT, including outreach case management, and service delivery. Procedural steps in implementing EPSDT are the concerns of Chapter III, including local level orientation, role of a steering committee, and planning. Chapter IV reviews examples of successful partnerships between local educational systems and EPSDT programs; and highlights the school's role in outreach, screening, and as full range provider. Extensive appendixes include lists of state and regional EPSDT coordinators and guidelines for interagency agreements between public health and EPSDT.

Lewis, Jordan D. "Secrets of Successful Strategic Alliances." ***Boardroom Reports,*** July 15, 1990, pp. 9-10.

This article provides an overview of strategic alliances, with discussions of selection of partners, basic types of alliances, and examples.

Lewis-Idema, Deborah. ***Increasing Provider Participation.*** National Governors Association, undated.

This paper discusses strategies for increasing provider participation in Medicaid, Maternal and Child Health, and other public programs for low-income pregnant women and children. After assessing the extent of concern with this issue among state programs and identifying factors which inhibit provider participation, the report identifies approaches which different state agencies are using to address these problems.

Although most of the strategies deal with reimbursement rates and malpractice issues, the report remarks that one important aspect of new state-level programs is increased coordination between Medicaid and Maternal and Child Health programs. These efforts offer the potential for better relating MCH-provided prenatal care with Medicaid payment for deliveries, thereby reducing physician concern about risk. Case management programs, continuous eligibility, and expanded benefits such as nutrition counseling are suggested as methods for increasing participation by obstetrical providers.

Liles, Ray and Wahlquist, David L. "Interagency Program for the Treatment of Intrafamilial Child Sexual Abuse." *Social Work Papers* 16: Spring 1981, pp. 24-32.

With the recent realization that intrafamilial child sexual abuse is much more widespread than formerly believed, many communities have been setting up specialized treatment programs. The Riverside (California) Interagency Sexual Abuse Council is discussed as an example of an integrated community service, sponsored by the Riverside County Departments of Health, Probation, and Social Services. Special attention is given to the relationship between interagency cooperation and service delivery. The program, begun in 1977, currently has 125 active patients organized into groups for children, adolescents, and parents.

Lindsey, Jennifer. *Joint Ventures and Corporate Partnerships: A Step-by-Step Guide to Forming Strategic Business Alliances.* Chicago: Probus Publishing Company, 1989.

This book provides practical advice on creating successful alliances with domestic corporations, the United States government, foreign corporations and governments, and offshore markets. Prototypes, model contracts, and case studies are discussed. Among the topics covered are preparation for an alliance, myths of joint venturing, selecting the right partner, risk tolerances, and resources and needs.

Lippitt, Ronald and Van-Til, Jon. "*Can* We Achieve a Collaborative Community? Issues, Imperatives, Potentials." *Journal of Voluntary Action Research* 10(3-4): July-December 1981, pp. 7-17.

We live in an increasingly interdependent world, and in increasingly interdependent nations and communities. Effectiveness in these societal contexts would, in all probability, be enhanced if people knew how to work together for the achievement of mutually-shared goals. Voluntary collaboration, however, is an unfamiliar skill for most individuals and groups. Hence, efforts to cooperate are often ineffective. A special issue of the *Journal of Voluntary Action Research* on interagency collaboration addresses this common deficiency and explores cases in successful collaboration.

Livingston, Dodie. *Activities of the Administration for Children, Youth and Families.* Washington, DC: Administration for Children, Youth, and Families, U.S. Department of Health and Human Services, 1985.

This report discusses initiatives of the Administration for Children, Youth, and Families (ACYF) in the areas of Head Start, child care, the National Center on Child Abuse and Neglect, support of historically black colleges and universities, foster care and adoption assistance, the Runaway and Homeless Youth Program, and current and future plans. The discussion of Head Start focuses on cooperative ventures with other agencies concerning running the Child Development Associate (CDA) program, parent involvement, transition to school, Head Start staff and child *caregiver* training, curriculum dissemination, mental

health, child health and safety, and adult illiteracy. National data concerning child care are reported. Efforts to provide public information and fund research and demonstration projects assisting parents, local communities, and States in meeting their child care needs are briefly described. Also described are ways the National Center on Child Abuse and Neglect meets its responsibility for generating knowledge and improving programs; collects, analyzes, and disseminates information; operates a State grants program; and coordinates federal efforts. Future directions of the Center, for FY 1986, are specified. Additionally provided are statistics and background information concerning foster care and adoption, along with capsule descriptions of past accomplishments and future objectives. Major strategies for the targeting of ACYF resources are revealed.

Locklear, Zoe Woodell. *Study of the Effect of Interagency Coordination on School-to-Work Transition.* Doctoral dissertation. The University of North Carolina at Chapel Hill, 1989.

The purpose of this study was to seek information about the relationship between interagency coordination and school-to-work transitions. Specifically, it focused on whether more comprehensive interagency coordination efforts are associated with more effective transitions and the relative impact of this interagency coordination on the transitions. Many writers have written in this area and have suggested certain components of effective school-to-work transition programs. Writers have also suggested components of interagency coordination, including that interagency coordination should be one component of an effective transition program. However, there has been little research in this area.

Based on a review of the literature, ten criteria that indicated or supported the concept of comprehensive interagency coordination were identified and nine criteria that supported transition effectiveness were identified. These criteria were used to guide the study. A qualitative approach was used as the basic design for this study. The specific research strategy employed was case studies. Data were analyzed using a qualitative analysis of variance method.

It was determined that differences in interagency coordination comprehensiveness between sites were insufficient to address the original research questions. General conclusions were drawn as follows: 1) an interagency council or community-level planning committee is advantageous for program development, 2) joint staff development can enhance interagency coordination and transition effectiveness, 3) the effectiveness of a school-to-work transition program can be enhanced if operating procedures are clearly addressed.

Maestas, Sam *IRCA/SLIAG Activities Conducted by El Progreso del Desierto, Inc.: A Community Approach.* Sam Maestas. Coachella, CA: El Progreso del Desierto, Inc., undated.

This booklet contains a collection of newspaper articles which reported the activities of El Rogreso del Desierto, a community/migrant health center, with regard to amnesty seekers under the IRCA/SLIAG legislation. The collection opens with a chronological listing of significant activities at the center. Among the activities reported are a cooperative effort by El Rogreso and local businesses and media to distribute food and toys to needy families at Christmas and a community-based effort to fund a mobile medical unit.

Magrab, Phyllis; Flynn, C.; and Pelosi, J. *Assessing Intemgency Coordination through Process Evaluation.* Chapel Hill, NC: State Technical Assistance Resource Team, September 1985.

This handbook, funded by the U.S. Department of Education, provides an overview of methods and instruments that may be used to review, analyze, and document interagency processes for developing and coordinating services for handicapped and at-risk children. Four interagency issues of significance to evaluation efforts are highlighted: 1) the existence of varied and conflicting definitions of interagency coordination, 2) differing purposes for involvement among agencies involved in interagency coordination, 3) many patterns followed by interagency coordination, and 4) the dynamic, interactive nature of the interagency coordination process. Factors that lead to successful evaluation efforts are addressed, including positive attitude toward coordination, recognized need for coordination, and capacity to maintain the coordination process. Examples of evaluation instruments and summaries of state and local evaluation studies of interagency coordination are appended.

Magrab, Phyllis and Striffler, Nancy. *Successful Models of Community-Based Care." *Childlink,* volume 3, number 3, Winter 1991, pp. 5 & 9.

This article reports on a meeting in which representatives from eleven states shared their community successes in identifying children with special health care needs, implementing care coordination, networking, etc.

Malinoski, Angela and Gressman, John W. 'Integrating a Family Planning Program with a County Health Department Based Maternal and Child Health Program." Paper presented at the Annual Meeting of the American Public Health Association, Las Vegas, Nevada, September 28-October 2, 1986.

This paper provides a description and analysis of the development, implementation, and continuing framework of practice for a model of comprehensive, coordinated maternal and child health programs, in which traditional maternal and child health services are provided by a local county health department while family planning and related services are provided by a private non-profit agency. Clients' benefits of increased accessibility, continuity, and coordinated

care are examined. It is noted that prenatal, child health, sexually transmitted disease, and nutrition services are integrated through formal and informal arrangements with the family planning provider. The paper discusses inter-staff interaction, communication patterns, problem-resolution techniques, formal and informal linkage agreements, and cost efficiency. Included in the presentation are reactions from patients, staff, administration, and outside agencies routinely involved with both programs. The cumulative result of the model is a larger pool of cooperating health and allied professionals to provide care and serve as resources for clients and families. The cost efficient approach is shown to be a model for the community at large, demonstrating a potential for less fragmentation of the health care system to the consumer. The overall impact is the framework for larger community networking and the implementation of an effective client/family advocate system.

Mason, Scott A.; Shaman, Hindy J.; and Dube, Monte. *Diversification and Conversion Strategies for Rural Hospitals.* Chicago: American Hospital Association, 1989.

This report discusses viable diversification and conversion strategies for rural hospitals which find themselves unable to remain solvent in their current form. The report discusses various entities, including community members, local medical professionals, major donors to the hospital, and regulatory agencies, who need to be included in the planning process for diversification or conversion. Also provided are case studies of rural hospitals which have successfully implemented diversification or conversion efforts.

Mathematica Policy Research, Inc. Savings *in Medicaid Costs for Newborns and Their Mothers from Prenatal Participation in the WIC Program, Volume 1.* Mathematica Policy Research, Inc. Washington, DC: U.S. Department of Agriculture, Food and Nutrition Service, Office of Analysis and Evaluation, October 1990.

A study was conducted in the five states of Florida, Minnesota, North Carolina, South Carolina, and Texas to investigate the relationship between prenatal participation in WIC programs and later Medicaid costs. The study findings suggested that prenatal participation in WIC improves birth outcomes and thus generates savings in Medicaid costs. The report cites increased coordination between Medicaid and WIC programs since completion of the study, which may result in higher-income women participating in WIC programs. The role of this and other changes on estimates of WIC benefits is uncertain.

McRae, John; Lawlor, Larry; and Nelson, Barnard. 'Counteracting Bureaucratic Resistance in Welfare and Mental Health-A Working Agreement Approach." *Administration in Mental Health* **12:** Winter 1934, pp. 123-132.

Working agreements and the spectrum of linkage mechanisms are explored as useful administrative tools for mental health and public welfare administrators. They are helpful when assessing the inter-organizational environment and identifying potentially useful linkages between their respective organizations

and other interdependent organizations. Planning must depend not only on internal resources, but also on external interagency cooperation and mutual support.

Merrimack Education Center. ***Lawrence Children's Health Project/EPSDT. A Proposal to Integrate Health and Special Education Services for Children in a School-Based Demonstration Project. Final Report.*** Chelmsford, MA: Merrimack Education Center, 1982.

This final report describes the Lawrence Children's Health Project (LCHP), set up in Lawrence, Massachusetts in 1979, in order to demonstrate and evaluate the feasibility and cost-effectiveness of an interagency approach to providing health care to children through a school-based local resource network. The LCHP service delivery is said to have met the mandates of both federal (Early Periodic Screening, Diagnosis and Treatment) and state (Special Education Chapter 766) laws. The project enrolled over 85 percent of the students in six schools and screened over 2,000 children. The major project elements are described: enrollment, screening-physical and developmental, referral, follow-up, client flow, training, billing, management information system (MIS), end brokering. A short discussion of future project activities is followed by a section dealing with the major milestones for each of the project's objectives: broker model; service delivery; MIS; training; and evaluation and dissemination. A financial statement is followed by detailed appendices: (1) a list of major project products and reports; (2) an early childhood pamphlet (English/Spanish); (3) an organizational chart; (4) a school health-policy guide ;(5) a summary report (Spring 1982); (6) a description of the microcomputer information system ; and (7) the Merrimack Education Center's letter of agreement with the Lawrence public schools. The report concludes that the LCHP has demonstrated that brokering of children's health care can be coupled with school-based EPSDT (Early Periodic Screening, Diagnosis end Treatment) services as a realistic alternative to conventional models of health service delivery for children.

Mooney, Kevin C. and Eggleston, Mary. "Implementation and Evaluation of a Helping Skills Intervention in Five Rural Schools." ***Journal of Rural Community Psychology*** 7(2) (Special Issue on Prevention and Promotion): Winter 1986, pp. 27-36.

This article describes a program in a southeastern Washington rural community mental health center to promote preventative interventions in five rural elementary and high schools, and to improve coordination between county social service agencies and rural schools. The article discusses implementation, acceptance, continuation, and evaluation of the program.

Morgan, Janet L. *Investigation of the Leadership Styles of Preschool Interagency Council Coordinators in Florida* Doctoral dissertation, University of South Florida, 1989.

> The purpose of this study was to provide information regarding aspects of leadership as they relate to preschool interagency council coordinators in Florida. The study examined the self-perceptions of 33 existing council coordinators relative to their leadership style, style range, and style adaptability, and compared results to the perceptions of 290 corresponding council members who reported their perceptions of the most appropriate leadership styles, range, and adaptability for coordinators. The study sought to identify whether differences in perception existed between the two groups, and the relationship between style, *range,* and adaptability and district size and stage of council development.
>
> The results of this study suggested that few differences may exist between the perceptions of coordinators and council members. Further, few differences may exist between councils that *differ* by size of district or by stage of development. Additional research is needed to investigate variables related to leadership skill among potential and acting coordinators and successful operation of these councils.

National Association of County Health Officials. *Primary Care Project: Report on the Nature and Level of Linkages between Local Health Departments and Community and Migrant Health Centers.* Washington, DC: National Association of County Health Officials, 1990.

> This report provides an overview of the background of the project which began in 1985 as a collaborative effort between the National Association of County Health Officials and the Health Resources and Services Administration and outlines benefits of forming linkages. It then describes methods and findings of a study of linkages between community/migrant health centers and local health departments.

National Center for Clinical Infant Programs. *Linkages: Continuity of Care for At-Risk Infants and Their Families: Opportunities for Maternal and Child Health Programs and Programs for Children with Special Health Needs. Report of a Work Group.* Washington, DC: National Center for Clinical Infant Programs, 1988.

> A work group convened by the Director of the U.S. Office of Maternal and Child Health examined the need and opportunity for a continuum of care to serve vulnerable populations of pregnant women and infants, and made recommendations for improving linkages among the various services needed by these mothers and their infants. Barriers to linkage between and among prenatal, perinatal, followup, referral, and early intervention services were noted. The work group recommended: standardized data collection among agencies concerning indicators/predictors of poor pregnancy and developmental outcomes, feedback to health care providers who make referrals to early intervention

programs, prenatal and parenting classes for expectant parents, provision of community services information to parents prior to hospital discharge of their newborns, effective pre-service and m-service training, collaboration with media to disseminate information, etc. An appendix indicates the lead agency that each state has designated for implementation of Public Law 99457, Part H, and outlines the legislation's 14 components essential to a comprehensive system of care for children from birth to 2 years and their families.

National Center for Clinical Infant Rograms. *Promoting Success in Zero to* **Three** *Services: The Spotlight. Service Coordination: More than a Buzzword?* Arlington, VA: National Center for Clinical Infant Programs, 1991.

This grant report discusses the need for service coordination in assistance to children and families and assesses the degree to which federal government, state government, and the professional community support the potential for local reform in reconfiguring services. The report includes a description of the National Health/Education Consortium, whose goal is "to improve the health and learning potential of children by discovering and disseminating ways in which those involved in providing both health and education services to children can work together."

National Center for Clinical Infant Rograms., *Promoting Success in Zero to Three Services: When What It Takes Is Leadership.* Arlington, VA: National Center for Clinical Infant Programs, May, 1991.

This report from the project "Promoting Success in Zero to Three Services" focuses on the importance of thoughtful, committed, and continuing leadership in collaborative undertakings. It quotes Atelia I. Melaville and Martin J. Blank, authors of a 1991 publication of the Education and Human Services Consortium called *What It Takes: Structuring Interagency Partnerships to Connect Children and Families with Comprehensive Services, with* respect to effective leadership in the context of interagency initiatives. Also included is a segment by Susan Colby, Chairman of the Fairfax Falls Church (Virginia) Interagency Coordinating Council, concerning leadership in her community.

National Clearinghouse for Primary Care Information. *Primary Care Perspectives* 7(1): *March* 1991.

This issue of *Primary Care Perspectives* focused specifically on networking and linkages for primary health care. It includes an editorial discussing reasons for creating linkages, including optimizing resources by reducing fragmentation or overlapping services, expanding the scope of services available to the community or the number of people who can be served, and strengthening relationships through the accomplishment of mutual goals. Also included is an interview with two community health center administrators, one in an urban setting and one in a rural setting, about their use of networking and linkages to serve their target populations. The administrators describe a number of model approaches,

discuss the factors that contribute to the success of their interagency efforts, and provide advice about overcoming barriers to cooperation. Finally, the issue contains an overview of a collaborative demonstration project in which community health centers and the Health Resources and Services Administration will identify areas around which to work together and develop a plan and schedule for implementation.

National Clearinghouse for Primary Care Information. *Primary Cure Perspectives* 7(2): May 1991.

This issue of *Primary Care Perspectives* reports on two examples of formal affiliations between community/migrant health centers with educational institutions, 1) Claretian Medical Center in Chicago with Cook County Hospital and Christ Community Hospital, and 2) Mountain Comprehensive Health Center in Whitesburg, Kentucky, with the University of Kentucky.

Staff members Dr. Rita Denise Woods and Executive Director Lois Baker "describe their experiences with and share their advice on the creation and management of such linkages." Also included in the issue is a report by the Virginia Primary Care Association on vital strategies for establishing professional educational affiliations.

National Governors' Association. *National Governors' Association Survey of Medicaid Cure Coordination Programs. Draft figures* from study, 1989.

These figures illustrate preliminary results from a study of Medicaid care coordination programs. Data include state plans using COBRA authority or Medicaid waivers for care coordination, implementation dates of care coordination systems, activities assigned to the care coordinator, populations receiving care coordination services, factors considered through a risk assessment approach, types of providers qualified to render care coordination, and reimbursement methods for care coordination services.

National Water Project. *Mesa Book: Cases in Migrant Environmental Services Assistance.* Leesburg, VA: National Water Project, 1988.

The National Water Project is supported by the federal Migrant Health Program to provide financial and technical assistance to local migrant health centers for environmental projects. Through its Migrant Environmental Services Assistance (MESA) project, the program has conducted many demonstration programs and projects across the U.S. Because many of the MESA grants are small, one focus of the program is to use these funds to leverage other funds from public and private sources. This book contains a description of the MESA project objectives and selection criteria, and the provides case studies of selected assistance provided through MESA. In addition, specific 'lessons" from the case studies are discussed in the final chapter, including a discussion of methods and concerns for leveraging MESA funding. This section also emphasizes the im-

portance of working in cooperation with local growers to find economically feasible ways to improve farmworker conditions,

Nelkin, Valerie. Six *State Collaborative Projects.* Chapel Hill, NC: University of North Carolina at Chapel Hill, Technical Assistance Development System, 1933.

This report describes efforts in six state projects demonstrating that communication and cooperation in state and local service delivery systems can improve services for children, especially preschoolers, with handicaps, State responses to questions of changes attributable to the project, additional resources received to continue the project, and useful project publications are summarized. The projects are characterized by concentration of efforts on the community level, focus on the preschool population, and emphasis *on* conducting in-service training. Abstracts of the six stats collaborative projects note the agencies involved, briefly describe the project, review strategies and methodologies, discuss predicted outcomes, and conclude with an explanation of interagency collaboration.

North Carolina Department of Human Resources. *Baby* Love *Medical Assistance Program.* Raleigh: North Carolina Department of Human Resources, undated.

The Baby Love Medical Assistance Program is aimed at reducing infant mortality by improving access to health care and support services for low-income pregnant women and young children. The program was developed cooperatively and continues to be administered jointly by the Division of Health Services, Maternal and Child Care Section and the Division of Medical Assistance of the North Carolina Department of Human Resources. The program has enlisted over 250 local service agencies to participate in a statewide resource and referral system; many of these agencies also participate in outreach activities for Baby Love. This information packet describes key program features and provides a preliminary assessment of the program's effectiveness.

One important element of the Baby Love program is care coordination, which is provided by a qualified maternity care coordinator through a formal case management process. This process consists of 1) outreach to assist clients in applying for Medicaid, develop a strong referral network, and increase community awareness of coverage and benefits, 2) recruitment of clients into maternity care coordination services, 3) assessment of clients' service needs, 4) service planning, 5) coordination and referral to ensure appropriate services and continuity of care, 6) follow-up and monitoring, and 7) education and counseling in preparation for childbirth and parenting. The program has also developed a provider agency protocol on developing a maternity care coordination delivery system for qualified providers. Included are local health departments with the required care coordination staff as well as other agencies which provide prenatal care services, serve Medicaid recipients, have qualified staff, and have a memorandum of understanding with the local health department.

Northwest Regional Primary Care Association. *Region X Interagency Profiling and Outreach Project for Migrant and Seasonal Farmworkers.* Seattle: Northwest Regional Primary Care Association, 1987.

The Northwest Regional Primary Care Association (NRPCA) received funding from the federal Migrant Health Rogram in 1987 for a regional, interagency effort with a dual purpose: 1) to obtain migrant and seasonal farmworker population data for every county in Idaho, Oregon, and Washington, and 2) to explore ways to increase farmworkers' access to health care. The project was coordinated by NRPCA in cooperation with interagency advisory groups from each state which included representation by state agencies, community-based service delivery organizations, farmers and growers, ethnic organizations, health providers, and migrant farmworkers.

This information packet provides information on the project background, need, purpose, evaluation/coordination methodologies, and project administration. Also included are notes on work group roles and work plans for the project.

Pindus, Nancy; Duggar, Benjamin; and Schultz, Carol. *Improving MCH/WIC Coordination : Find Report and Guide to Good Practices.* Washington, DC: U.S. Dept. of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation, 1986.

This report presents findings and recommendations of a study of coordination between the Maternal and Child Health Program of the Department of Health and Human Services and the Special Supplemental Food Program for Women, Infants and Children (WIC) of the Department of Agriculture. This study was conducted by Professional Management Associates, Inc., under contract to the Office of the Assistant Secretary for Planning and Evaluation, DHHS, in cooperation with USDA. The purpose of this project was to identify issues involved in the relationship between the two programs, study how the issues are best resolved at the federal, regional, state and local levels, and prepare a report covering: (1) a guide to good practices showing how coordination can be accomplished within different administrative structures; and (2) a final report describing study purpose, methods, findings, and recommendations.

Porter, Kathryn H. *Making JOBS Work What the Research Says About Effective Employment Programs for AFDC Recipients.* Washington, DC: Center on Budget and Policy Riorities, March 1990.

Among other programs, the Family Support Act of 1988 covers the Job Opportunities and Basic Skills (JOBS) Training Rogram, which requires states to establish employment programs for recipients of Aid to Families with Dependent Children (AFDC). The legislation was passed at a time when considerable research was being conducted to address the most effective ways to assist AFDC recipients in finding employment and increasing their earnings. This report

synthesizes some of the most significant findings and relates them to the decisions faced by the. states as they implement JOBS programs.

The report specifically addresses maximizing limited funding by using education, employment, and training services provided by other agencies. Linkages to education and training agencies are encouraged as a way to help the various programs to fulfill their own obligations to their service population. In addition, the Family Support Act requires the establishment of working relationships with other agencies. This requirement necessitates closer coordination with education agencies and private educational institutions, as well as with *other* public programs.

Prahalad, C. K. and Hamel, Gary. "Core Competence of the Corporation." *Harvard Business Review* May-June 1990, pp. 79-91.

Discusses the advantages of reforming management principles to focus on acquiring and developing competencies through use of collaborative arrangements to multiply internal resources, identifying core competencies in a company, building competencies, etc.

Project Share. *Managing the Human Service "System": What Have We Learned From Services Integration?* (Human Services Monograph Series, Number 4). Denver, CO: Project Share, 1977.

This monograph reports on the methods and findings of 45 Services Integration-Targets of Opportunity (SITO) Projects most of which were involved in the establishment of state or local interagency linkages. Definitions of interagency linkages delineated in Appendix 2 were first presented in *Integration of Human Services in HEW* by Marshall Kaplan, Gans and Kahn and the Research Group; where noted the definitions depart from and contrast with the originals. Linkages are categorized as fiscal, personnel, planning and programming, administrative support service, core service, and case coordination linkages.

Regens, James L. "Institutional Coordination of Program Action: A Conceptual Analysis." *International Journal of Public Administration* 11(2): March 1988, pp. 135-154.

The absence of interagency cooperation represents a major barrier to efficient and effective program action in the public sector. Achieving and sustaining institutional coordination is difficult. Six key factors that may foster or constrain intergovernmental cooperation are identified, including perceived urgency of *the* problem, its costs and potential financial and legal liabilities, the need for technical expertise and financial assistance, the presence of public pressure, the relative openness of communication, and clear jurisdiction on the part of governmental entities. Coordination efforts are contingent upon the success or failure of three approaches to institutional coordination: 1) orchestration from above, *2)* self-linking among functional professionals, and 3) meshing from below. Institutional coordination represents a complex decision about allocating authority and responsibility as well as setting priorities for program action.

Robinson, James C. "Philosophical Origins of the Social Rate of Discount in Cost-Benefit Analysis." *Milbank Quarterly* 68(2): 1990, pp. 245-264.

> Examines the economic and philosophical arguments that surround discounting to clarify the issues at stake in cost-benefit analysis for programs with significant inter-generational implications. These include traditional public health investments in sewage and toxic waste treatment facilities, basic biomedical research, efforts to slow ozone depletion and global warming, energy policy, and many more.

Rogers, Sally E.; et al. "Impact of Interagency Collaboration on System and Client Outcomes." Sally E. Rogers, et al. *Rehabilitation Counseling Bulletin* 33(2): December 1989, pp. 100-09.

> This article describes a project that was aimed at improving the rehabilitation outcomes of people with severe mental illness in rural settings through improved interagency collaboration between mental health and vocational rehabilitation systems. Interagency collaboration was examined through measures of perceived collaboration among practitioners and administrators and vocational rehabilitation data.

Rosenbaum, Sara, ed. *Community and Migrant Health Centers: Two Decades of Achievement.* Compiled and edited by Sara Rosenbaum. Washington, DC: National Association of Community Health Centers, 1986.

> In question-and-answer format, this paper discusses who needs health centers, why health *centers are so* important, how effective health centers have been in carrying out their mission, and how cost effective community health centers are.

Rural AIDS Network. *Rural AIDS Network Regional and National Program Outline.* Publisher not identified, undated.

> The Rural AIDS Network is a national consultation and training coalition focused on people with AIDS/HIV as well as service providers. Through cooperative agreements among service providers, Rural AIDS Network anticipates strengthening the local AIDS/HIV outreach through training and skills-building geared toward improved self-sufficiency, coalition-building, and long-range planning. The network highlights the unique resources of rural locales and the inter-relationships possible without reliance on urban resources.
>
> This program outline provides an overview of the problems end describes the goals and objectives of the Rural AIDS Network. As part of its training efforts, RAN master trainers facilitate the formation of regional networks designed to assist in gaining cooperation and coalition-building between diverse groups and individuals involved in local AIDS/HIV education and services. The regional networks also support service providers in identifying and providing needed resources in areas with low to medium incidence and limited services.

Also described are Rural AIDS Network efforts to encourage organization of local People With Aids Coalitions, conduct a National Rural AIDS Institute, and communicate through a quarterly newsletter. Methodologies for these efforts are summarized. Finally, network personnel, facilities, and evaluation and long-range planning are discussed.

Safewright, Marcia Porter. *Dimensions of the Interorganizational Relationship Between Area Agencies on Aging and Social Services Block Grant Agencies.* Doctoral dissertation. Virginia Polytechnic Institute and State University, 1990.

This research employed a model of inter-organizational relations based on social action theory to examine the interagency relationships between Title III/Area Agencies on Aging (AAA) and Social Services Block Grant (SSBG) agencies across the country. The specific purpose of this study was to investigate five AAA/SSBG agency relationships using case study methodology to determine the adequacy of the existing model in portraying the relationships. It also examined possible changes in the framework that might enhance its ability to characterize the relationships.

In general, qualitative data analysis supported the model's ability to depict the interagency relationships. The following factors were influential in the formation and continued functioning of at least three of the five interagency relationships: 1) resource needs, dependence, and exchange; 2) a commitment to serving older adults; 3) a commitment to the interagency relationship; 4) interagency communication, awareness, and information exchange; 5) interagency consensus (i.e., agreement between agency representatives on the goals and expectations of each agency in the relationship); 6) domain similarity (e.g., overlap in client populations and geographic service areas); (g) informal means of interaction and communication; and 7) perceived effectiveness of the interagency effort by agency representatives.

Based upon the results of this investigation, the dissertation proposes a revised framework that incorporates the major components of the original model but also simplifies and conceptually clarifies important relationship factors. It places more emphasis on the individuals involved in interagency relationships and is tailored to fit the special circumstances of social service agencies. An important implication of these findings for further research is the need for examining other social service agencies with the original and revised framework to further enhance their usefulness in characterizing interagency interaction. Implications for practice include the use of this information about AAA/SSBG agency relationships to improve interagency collaboration, service delivery and planning, and public policy decisions.

Salerno, Sharon E.; Stavisky, Judith S.; and Holmes, Carolyn G. *HealthPASS... One Year After Implementation.* Philadelphia: Greater Philadelphia Health Action, Inc., June 1987.

The escalating costs of health care delivery have posed severe problems for public assistance programs. The Pennsylvania legislature charged the state Welfare Department with developing health care cost containment measures for publicly-funded programs. As a result, the Welfare Department adopted a Health Insuring Organization (HIO) plan whereby the Department would contract with a health insuring organization which would serve as the fiscal agent for the administration of health care services to medical assistance recipients. In March 1986, the Accessible Services System known as the Philadelphia HealthPASS Program was implemented. HealthPASS benefits included hospital in-patient and emergency room services; laboratory and X-ray services; physician, optometrist, and chiropractic services; home health care; emergency ambulance transportation; dental care; medical equipment and supplies; drugs; hearing aids; eyeglasses; and psychiatric clinic services (including methadone and drug/alcohol clinics).

This report provides a history of Greater Philadelphia Health Action's participation as a HealthPASS provider. Methods for tracking and case management of patients are discussed, with an explanation of the information sharing, cost, and quality control activities which link health services for public assistance recipients.

Schenet, Margot A. *State Education Agency Coordination Efforts. Summary Report.* Washington, DC: Urban Institute, 1982.

A study of state education agency (SEA) activities investigated the incentives and disincentives to coordination and interagency cooperation at the state level as well as the effects of federal initiatives and recent fiscal strains on these activities. Research focused on how much coordination currently exists nationwide; case studies of Pennsylvania, Colorado, California, and Washington examined whether the level of resources has an impact on the amount of coordination taking place, and the local impact of coordination. Across the 50 states very little coordination exists between education and other state agencies providing human services. Intensive interviews with key personnel in the four states revealed coordination efforts to be minimal among programs within education agencies. In none of the four cases did declining resources spur agency initiatives for coordination, though state legislatures did push agencies in the direction of greater coordination. Finally, formal agreements at the state level do not determine the extent of joint activities at the local level. Only SEAs that use interagency agreements to establish working relationships between local offices of social and health service agencies and local school districts are likely to have an impact on local operations.

Shapiro, Isaac and Greenstein, Robert. *Holes in the Safety Nets: Poverty Programs and Policies in the States.* Washington, DC: Center on Budget and Policy Priorities, April 1988.

> Rather than a single "safety net" covering all poor populations of the United States, there are separate and differing safety nets in each state. The Safety Nets Project was created to examine these various safety nets. The report covers cash and medical assistance programs, food stamps, unemployment insurance, low-income housing and energy assistance programs, WIC, and tax policies. The findings indicate that there are many gaps in the states' safety nets, and the report makes a number of recommendations on ways to reduce these gaps in order to help alleviate the effects of poverty and to diminish the ranks of the poor, It is suggested that stronger federal standards for safety net programs are needed. These standards would include the establishment of a federal floor for AFDC benefits, a requirement that states provide AFDC benefits to families with unemployed parents, a requirement that all Supplemental Security Income recipients be made eligible for Medicaid, federal action to require the extension of Medicaid coverage to more children in poverty, and enactment of a revised federal "trigger" which makes it likely that. states with high unemployment rates would be eligible for programs which extend unemployment insurance benefits for the long-term unemployed.

Shotland, Jeffrey. *Full* Fields, *Empty Cupboards: The Nutritional Status of Migrant Farmworkers in America.* Jeffrey Shotland. Washington: Public Voice for Food and Health Policy, April 1989.

> This report summarizes the findings of a study on nutrition among migrant and seasonal farmworkers in Virginia and Florida. The report reviews the health and nutritional status of these workers and makes a number of recommendations. Among these are key recommendations regarding access to food stamps, emergency food, and other public assistance programs for farmworkers. Suggestions focus on the areas of outreach, expedited service, bilingual staffing, office hours, and transportation to allow farmworkers to use the Food Stamp program; expanded availability of emergency food to migrant farmworkers; expanded WIC program entitlement to provide benefits to a higher proportion of eligible farmworkers; and development of a uniform national application form to be made available to migrant farmworkers for AFDC and Medicaid.

Simmons, Jeannette J. "Interorganizational Collaboration and Dissemination of Health Promotion for Older Americans." *Health Education Quarterly* 16(4): Winter 1989, pp. 529-50.

> This article describes how Staying Healthy after Fifty, a successful health promotion program for older adults, was adapted and disseminated through the collaboration of three agencies. Includes the conceptual framework used to build the relationship, the outcomes, and an analysis of the experiences as they relate to diffusion of innovation.

Stafford, Beth G.; et al. *Creation and Activities of Local CARE Committees: A Manual on Stimulating Local Collaborative Efforts Relating to Preschool Services.* Nashville: Tennessee Children's Services Commission, 1984.

One of four volumes devoted to the CARE (Children's Agencies, Resources, Etc.) Linkages Project in Tennessee, this report describes the development of eight county CARE committees. The goal of the project was to foster collaboration leading to more effective linkages between publicly funded child care and development programs and other service providers. Four in-service training sessions were provided by the state and local CARE coordinators for district program coordinators. These sessions focused on creating, staffing, and documenting the activities of local CARE committees. As a result of the sessions, lists of suggested local CARE committee members were developed. These differed according to geographical area, but in general included professionals from public and private preschools and day care centers, health and environmental agencies, the local school system, the Department of Human Services, and local councils and volunteer groups. The sessions also generated an agenda to follow at the first CARE committee meeting and clarified the role district coordinators should play. Numerous appendices include training materials, documents created for committee record keeping, and a summary of committee activities in each of eight counties.

Struyk, Raymond J.; et al. *Providing Supportive Services to the Frail Elderly in Federally Assisted Housing.* Washington, DC: The Urban Institute Press, June 1989.

This study estimates the number of frail elderly in federally assisted housing who are at significant risk of institutionalization. It then reviews existing state and federal efforts to serve this population, and explores possible new service approaches. Included is a discussion of the necessity of an effective mechanism to coordinate the provision of supportive services for a successful congregate housing program, and discusses the strengths and weaknesses of several alternate means to provide this coordination. The report also presents models whereby more states could be encouraged to become involved in serving their own frail elderly populations, and makes recommendations on how best to structure and fund such programs.

Texas Association of Community Health Centers. "Roposal for Shared Service Arrangements Among Primary Care Roviders in Texas." Austin: Texas Association of Community Health Centers, undated.

The Texas Association of Community Health Centers submitted this application for grant support to develop a Shared Services System for the state's health centers to the U.S. Department of Health and Human Services. The proposal describes a system which has the following objectives: 1) assessment of project needs as they relate to shared services; 2) continuing education activities for various types of clinic personnel; 3) implementation of a plan for medical recruitment; 4) consortium development and implementation; 5) development

of memoranda of agreement with other entities, including state agencies and other associations; 6) provision of technical assistance in strategic planning; and 7) exchange of resources to utilize existing expertise among the primary care centers.

The proposal describes the problem of providing continuity of primary health care in Texas, and the structure and role of TACHC in coordinating health center activities. As a method for addressing shared resources, the proposal would create a network consisting of a reference library of contracts, health plans, patient care protocols, and other pertinent documents; a mutual assistance pool offering assessment of clinic needs, provision of technical assistance services, and compilation of a network of "experts" in clinic management and operation; and a continual education/in-service component for medical and dental providers, ancillary staff, social services staff, health education, and administrative and financial personnel. Other cooperative efforts would include a joint purchasing program and development of agreements for recruitment efforts with the Texas Department of Health, medical schools, and the Texas Medical Association.

Texas Department of Human Services. *Partners for Self-Sufficiency: Colonias in the Rio Gmnde Valley of Texas.* Plano: Frito-Lay, Inc., undated.

Colonias are unincorporated rural subdivisions characterized by substandard housing and inadequate water, sewer, and plumbing systems. This booklet describes a two-part, cooperative initiative to address immediate and long-term needs in the colonias. The project involves community leaders, business leaders, educators, health providers, the religious community, service organizations, philanthropic corporations, and government agencies.

Through a human service initiative, case managers for the project will link families to the resources needed to achieve their plans. The community partnership facet of the project will use the need assessment information developed by the case managers to fill resource gaps. Business and community leaders participating in the partnership will secure funding and donated equipment or supplies from foundations, corporate contributions, and agencies.

Trohanis, P. L. *Compamtive Analysis of Selected Federal Pmgmms Serving Young Children: Steps Toward Making These Programs Work in Your State.* Chapel Hill, NC: State Technical Assistance Resource Team, September 1936.

With funding from the U.S. Department of Education, the author analyzed seven federally funded programs which have significant impacts on state planning and are important to special needs children: 1) Medicaid, 2) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), 3) Child Welfare Services State *Grants, 4)* Head Start, 5) Maternal and Child Health (MCH) Services Block Grant, 6) Social Services Block Grant (SSBG), and 7) Education of the Handicapped Act (EHA). The eligibility criteria for the populations that may

benefit from each program are reviewed, and attention is focused on whether development of a state plan is required for use of the funds, whether provisions are made for interagency coordination activities, whether a system for case management is provided, and whether a written, individualized service or program plan for each child or family is required. Finally, use of the funds for diagnostic services, habilitation/intervention services, or personnel training is considered.

Troolin, Barbara Louise. *Perceptions of Committee Functioning: Measuring Dimensions* of *Community Planning for Transition of Special Education Students in Minnesota* Doctoral dissertation, University of Minnesota, 1989.

Unique legislation passed in Minnesota that established Community Transition Interagency Committees (CTICS) for the purpose of community based planning and service coordination for youth with disabilities exiting public education. The purpose of this study was to measure the operational ability of the CTICs. This was accomplished through the development and testing of an instrument that measures perceptions of committee functioning, as reported by over 40 chairs and 470 committee members.

'Iwo surveys were developed to measure committee functioning by collecting data on how the committees operate (methods), on what committees do (tasks) and the committees' results (outcomes). By using factor analysis and regression analysis, methods data from committee members showed a low explanatory power to results/outcomes of the CTICs. Methods data were also used as a tool to explain tasks as reported by chairs. Few variables predicted tasks, with the exception of a question on CTICs addressing outcomes for youth with disabilities. Tasks were then analyzed to explain the results/outcomes data. The correlation was notable on some variables, including an inverse relationship with the presence of bylaws and written procedures. Finally, methods plus tasks data were used in regression analysis to explain results/outcomes of CTICs. The combination of these two dimensions showed a stronger correlation, with several variables being significant.

U.S. Department of Agriculture, Food and Nutrition Service. 'Special Supplemental Food Program for Women, Infants, and Children (WIC): Nonfunding Mandates of the Child Nutrition and WIC' Reauthorization Act of 1989." *Federal Register* 55(131):28033-28048, July 9, 1990.

This proposed rule would make a number of changes to the regulations governing the WIC program to comply with mandates in the Child Nutrition and WIC Reauthorization Act. Department-wide requirements for grants and cooperative agreements to state and local governments would be incorporated by reference into the WIC program regulations. Provisions regarding local program coordination with hospitals, referrals to other health-related or public assistance programs, and concurrent implementation of WIC and Medicaid income eligi-

bility are discussed, followed by the actual proposed modifications to the WIC regulations.

U.S. Department of Agriculture and U.S. Department of Health and Human Services. "Joint Statement of Cooperation Between the USDA Supplemental Food Programs and the DHHS Migrant Health Program." Unpublished document, July 1980.

This internal document was developed by the U.S. Department of Agriculture Supplemental Food Programs and the U.S. Department of Health and Human Services Migrant Health Program to outline possible areas for cooperation between the two programs. While the statement concludes that true integration of services is best accomplished at the local level, it recognizes that cooperation at the federal level is necessary to allow state and local agencies to coordinate programs. Therefore, the two agencies pledge to continue reviewing their operations to integrate federal management guidance and policies which support the efforts of regional, state, and local agencies in their integration efforts, and to extend technical assistance as necessary to achieve integration at the local level.

The document describes the purpose and services of the Special Supplemental Food Rogram for Women, Infants, and Children (WIC), Commodity Supplemental Food Rogram (CSFP), and Migrant Health Program, and identifies mutual goals for improving the nutritional and health status of migrant and seasonal farmworkers through provision of services. Regulatory requirements for selection of migrant-oriented local agencies for WIC services, transfer of WIC certification among jurisdictions, coordination of program operations with special counseling services and other programs, outreach efforts, expedited processing for high-risk participants, bilingual services, funding of services to migrant and seasonal farmworkers, and transportation costs are discussed, along with potential means of meeting these requirements. It is suggested that local evaluation of WIC and migrant health center strategies may lead to developing or implementing creative nutrition/health education methodologies, adjusting hours of operation for convenience, developing innovative outreach approaches, developing or strengthening support service capacities such as transportation and bilingual staff, or strengthening methods that assure continuity of services.

U.S. Department of Agriculture and U.S. Department of Health, Education, and Welfare. 'Nutrition Education and the Special Supplemental Food Program for Women, Infants, and Children (WIC)." Unpublished document, April 1977.

This Federal Agency Statement is a joint position statement by the USDA Food and Nutrition Service, USDA Extension Service, DHEW Bureau of Community Health Services, and DHEW Indian Health Service. The purpose of the document is to strengthen working relationships among federal agencies and their regional, state, and local counterparts in implementing the nutrition education component of the Special Supplemental Food Rogram for Women, Infants, and Children (WIC). The WIC program history and purpose are discussed briefly,

with emphasis on the mandated nutrition education component of the program. The statement stresses the need for consistency among the nutrition content and materials employed within state WIC programs to avoid confusion among recipients, provide maximum reinforcement of the nutrition education message, and permit each cooperating agency to more effectively supplement or follow-up nutrition education initiated by another agency.

The document gives a brief overview of the nutrition education priorities and services of the Food and Nutrition Service, Bureau of Community Health Services, Indian Health Service, State Cooperative Extension Service, state and local WIC agencies, and state and local health agencies, and suggests educational institutions and trade and professional associations as possible resources for provision of nutrition instruction.

Cooperative relationships are outlined, with a definition of leadership roles in planning of WIC nutrition services and assignment of responsibility for WIC program implementation. Finally, the document suggests several possible means for coordination of nutrition education, including the appointment of one individual for each state to assume major responsibility for coordination, formation of an advisory committee which includes broad representation from the various agencies which contribute to the nutrition education effort, and development of a plan which clearly defines the roles and responsibilities of the various individuals and groups contributing to nutrition education for WIC participants.

U.S. Department of Education and U.S. Department of Health and Human Services. *Meeting the Needs of Infants and Toddlers with Handicaps. Federal Resources, Services and Coordination Efforts in the Department of Education and Health and Human Services.* January 1989.

This document is a report to the Congress on the Handicapped Infants and Toddlers Program. The program, established in the Education of the Handicapped Act Amendments of 1986, focuses national attention on the needs of families with infants and toddlers who experience or are at risk of having handicaps. The legislation provides impetus and assistance to coordinate federal, state, and local efforts on behalf of these young children and their families. The coordination is a part of a broader system that has been put in place to assist individuals with disabilities from birth through adulthood. The report outlines an interagency agenda to provide national leadership to improve early intervention services that enhance development and minimize the later dependence of infants and toddlers with handicaps. The report describes the federal commitment to these services and the activities to achieve the goals of the Handicapped Infants and Toddlers program.

U.S. Department of Health and Human Services. *Assessment of the Comprehensive Perinatal Care Program.* Rockville, MD: Department of Health and Human Services, 1991.

This report presents findings and recommendations from a study of the Comprehensive Perinatal Care Program operated at nine community/migrant health centers chosen as regionally representative, providing an urban, rural, and migrant mix. They include tow centers with programs targeted to the homeless, substance abusers, or persons with HIV-related conditions. Site visits included discussions with key personnel, review of a sample of twenty randomly-selected medical records, interviews with center clients, and a validation of the data on the Perinatal User Profile.

The first section of the report details the study methodology and findings. The second section contains the nine case studies.

The purpose of the assessment is to identify key issues and make recommendations to enhance the perinatal programs and improve the delivery of comprehensive, case-managed care in community and migrant health centers. The study was conducted by Macro Systems for the Division of Special Populations and Program Development, Bureau of Health Care Delivery and Assistance.

U.S. Department of Health and Human Services. 'Coordination with Belated Agencies and Programs." U.S. Department of Health and Human Services. *State Medicaid* Manual, Part 5 - EPSDT. Chicago: Department of Health and Human Services, undated.

Federal, state, and local governments increasingly emphasize cooperation and collaboration in providing health services to Medicaid-eligible individuals. This section of the state Medicaid manual addresses cooperation, with the goals of 1) containing costs and improving services by reducing duplications and closing gaps in available services, 2) focusing on specific population groups or geographic areas in need of services, and 3) defining the scope of maternal and child health programs in relation to each other. The document discusses the scope and content of written interagency agreements between Medicaid agencies and other entities charged with planning, administering, or providing health care to low-income families.

Relationships between Medicaid and state maternal and child health and/or Crippled Children's Services programs, state and local educational agencies, Head Start, WIC, housing programs, Title XX, and other potentially productive alliances are addressed. Special emphasis is placed on cooperation with state maternal and child health and Crippled Children's Services programs, with discussion of organization and administration of such programs, financing of services to Medicaid beneficiaries, standards of care, mutual referral arrangements, outreach activities, inter-program activities, and indicators of inter-program effectiveness.

U.S. Department of Health and Human Services. 'Coordination with Related Agencies and Programs." State *Medicaid Manual,* Part 5, pp.5-42 • 5-52. Chicago: Department of Health and Human Services, undated.

This segment from the manual emphasizes cooperation and collaboration in providing health services to Medicaid-eligible individuals. It discusses interagency agreements, relations with state Maternal and Child Health (MCI-I) and Crippled Children's Services (CCS) programs, with state or local education agencies, with the Special Supplemental Food Program for Women, Infants and Children (WIC), and with Social Service (Title XX) Rograms.

U.S. Department of Health and Human Services. 'Diabetes Control Activities in High Risk Populations." Memorandum of Agreement between the Centers for Disease Control and the Health Resources and Services Administration, signed November 9, 198'7. Department of Health and Human Services, 1937.

The National Diabetes Advisory Board prepared a long-range plan for the prevention and treatment of diabetes. This memorandum of agreement is a response to the Advisory Board's recognition of opportunities for HRSA health care delivery and training programs through cooperative activities with CDC. The agreement was developed to facilitate the implementation of the Advisory Board's long range plan by describing projects which were agreed to in principle by both agencies. These projects include increasing linkages between CDC diabetes control programs and HRSA health car&raining programs; facilitating increased dissemination, use, and evaluation of existing and new guidelines for diabetes care and control; collaborative community models on effective practice in primary care settings; dissemination of information about CDC and HRSA diabetes-related resources; improvement of data on morbidity, mortality, and outcomes in populations served by HRSA programs; development of clinical personnel training and patient education programs; and provision of on-going program monitoring and evaluation.

U.S. Department of Health and Human Services. *Health Promotion and Disease Prevention: An Assessment Guide for BHCDA Projects. Administmtive Document.* Washington, DC: Medicus Systems Corporation, 1933.

Designed to help health center administrators and providers deliver health care services within the broad context of disease prevention, health promotion, and health education, this guide serves as a companion document to "Promoting Health and Preventing Disease: **Objectives for the Nation."** Its **purpose is to help in** program planning and to offer assessment guidelines for specific project needs. The guide is organized into five major sections: (1) Assessing Your Health Promotion and Disease Prevention Rogram: An Overview; (2) Reventive Health Services; (3) Health Protection; (4) Health Promotion; and (5) References. Each section, through a format consisting of one or two introductory paragraphs followed by clusters of questions grouped under subheadings, considers five areas: (1) needs assessment; (2) program linkages-offering sugges-

tions for developing cooperative working arrangements with organizations having similar goals; (3) health promotion and education-focusing on ways of enabling patients to assume more responsibility for their own health care; (4) program evaluation; and (5) resources.

U.S. Department of Health and Human Services. "Intra-Agency Agreement Between Migrant Head Start Program, Administration for Children, Youth and Families, Office of Human Development Services and Migrant Health Program, Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration." (For fiscal years 1984, 1985, 1986)

The purpose of this intra-agency agreement is to coordinate policies at the national level and to express the commitment of the Migrant Health Program and the Migrant Head Start Program to foster strong working relationships at the local level for assuring availability, accessibility, and quality of child health care in each state. The programs are briefly described and agreements are outlined in regard to health services, health services funding, health education, clinic visits, hours of operation, referral system, data sharing, and agreement conditions such as duration of agreement, period, modification/cancellation provisions, and cost.

U.S. Department of Health and Human Services. *MCH/WIC Coordination Study.* Professional Management Associates, Inc., 1986.

This study was undertaken to obtain information about state and local WIC programs and their relationship with the Maternal and Child Health program, with emphasis on the successful coordination of programs. The study tools include instructions and notes for site visits; discussion guides for the regional, state, and local levels; data collection forms for profiling state and local delivery systems; a data collection form for summarizing the state profile; and a listing of background literature.

U.S. Department of Health and Human Services and U.S. Department of Education. *Migrant Health/M&ant Education Coordination For Health Services to Migrant Children : An Interagency Agreement.* February 1934.

This paper discusses an agreement entered into on December 4, 1979, by the Department of Health and Human Services and the Department of Education in order to coordinate their efforts of extending health care services to migrant children enrolled in their respective programs. The major provisions of the agreement provided program guidelines that 1) identified specific health services to be provided by each program to migrant children, 2) recommended funding sources and cost formulas for health services to be provided, and 3) mandated medical information exchange between both programs through linkage with the Migrant Student Record Transfer System (MSRTS) and the National Migrant Referral Project (NMRP, now named National Migrant Resource Program). The implementation of the NMRP/MSRTS linkage, the

operation of retrieval and updating of information, cost, and recommendations for ensuring that the interagency agreement remains an effective mechanism are briefly outlined here.

U.S. Department of Health and Human Services, Bureau of Health Care Delivery and Assistance. *Background and Charge to Task Force.* BHCDA External Linkages/External Affairs Task Force. Rockville, MD: U.S. Department of Health and Human Services, June 22, 1990.

Discusses the background and charge to the Task Force which is reviewing the current status of BHCDA relationships with external organizations and recommending a course of action for 1990 and beyond. This document reports on the deliberations of the Task Force on May 31, 1990 concerning BHCDA mission and external affairs goal statements, external relationships, and relationships with state and local governments and health departments, health professional organizations, and special interest organizations at the national, regional, state, and local levels.

U.S. Department of Health and Human Services, Public Health Service. "Cooperative Agreements To Support National Health Promotion and Disease Revention Initiatives; Notice." *Federal Register* 54(24):6090-6095 (February 7, 1989).

Among the ODPHP priorities for 1989 was fostering partnerships with the private sector to further the reach of health promotion and disease prevention activities and programs. This issue of the Federal Register announces funding available through the Office of Disease Prevention and Health Promotion for national membership organizations that represent a number of special populations or settings including Blacks, Hispanics, Asians, people with disabilities, older people, adolescents, children and schools, work sites, and clinical settings. Nine cooperative agreements were funded to stimulate the development of targeted health promotion/disease prevention programs and policies for these populations and/or settings. Agreements focused on three areas: developing a National Worksite Health Romotion Resource Center, to promote healthy school lunch programs, and to put the Year 2000 National Health Objectives into practice.

The announcement describes eligibility requirements, funding periods and amounts, terms and conditions, and special considerations. In addition, information is provided on the application process, review and selection process, and evaluation criteria.

U.S. Department of Health and Human Services, Public Health Service. *Draft Recommendations Formulated by the Public Health Service Workshop Promoting the Oral Health of Mothers and Children.* Washington, DC: Department of Health and Human Services, September 12, 1989.

In September 1989 a group of 125 health professionals and consumer advocates met to address the oral health needs of mothers and children in the United

States. A series of recommendations were formulated for public and private health organizations, agencies, and institutions, as well as local, state, and federal governments. Of particular interest are the recommendations of the Integration and Collaboration Work Group, which addressed barriers to care imposed by lack of integration and collaboration among oral health and general health care professionals. In addition, the recommendations address the absence of an oral health component from the daily educational practices of health educators, day care workers, general health practitioners, and teachers.

Recommended strategies include application of case management principles to oral health services; development of a marketing plan for public health education on the importance of early and preventive care and access; improvement of Medicaid reimbursement levels for all services; inclusion of oral health initiatives within the Maternal and Child Health Program; inclusion of oral health services and issues within legislative initiatives; inclusion of dental activities in demonstration projects for increasing provider participation in Medicaid and EPSDT; and development of dental health professional education programs that recruit culturally diverse students, offer clinical training in interdisciplinary settings, and provide incentives for practice in under-served areas.

U.S. Department of Health and Human Services, Public Health Service. *Information/Education Plan To Prevent and Control AIDS in the U.S.* Rockville, MD: Department of Health and Human Services, March 1987.

This narrative report presents a PHS plan for public education on the causes, prevention, and control of acquired immune deficiency syndrome. The plan involves the cooperation of federal, state, and local government agencies and private groups. Groups targeted by the plan are the general public, youth, high-risk groups, and health workers. The report also includes text statistics on AIDS cases by risk group, and deaths as of March 1987 and projected to 1991.

U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Romotion. *Locating Funds for Health Promotion Projects.* Washington, DC: Department of Health and Human Services, March 1988.

The focus of this document is on raising funds from community organizations, foundations, corporations and non-profit groups, and public agencies for health promotion projects. However, general information on interagency coordination is provided, with emphasis on collaboration on projects to minimize duplication of effort, enable pooling of resources, and provide a variety of support. In addition, the advantages of linking up with existing programs to build on existing visibility and expertise and reduce costs by sharing staff and resources are discussed. Networking is cited as an invaluable source of information on potential funding sources. The document also provides addresses and information on a variety of resources such as The Foundation Center, DHHS Regional Offices, federal clearinghouses and information centers, and on-line databases.

U.S. Environmental Protection Agency. *Activities of EPA Assistance Programs and Interagency-Intergovernmental Agreements*. Washington, DC: Environmental Protection Agency, monthly periodical.

This publication reports on activities of EPA pollution control grant assistance programs includes new grant awards and interagency and intergovernmental cooperative agreements. Data are primarily from the EPA Grants Information and Control System and monthly regional reports on grant activities. Each issue contains narrative highlights and tables showing number and value of grant awards, progress in processing cooperative agreements, active and completed projects, and status of funds, by program, state, region, and outlying area. Data are shown for the current month and/or fiscal year to date, often with comparisons to previous year and cumulative totals from program inception. The report has been issued since 1972.

U.S. Environmental Protection Agency and U.S. Department of Health and Human Services, Bureau of Health Care Delivery and Assistance. 'Protection of Migrant and Seasonal Farmworkers from Health Effects Belated to Pesticides." Interagency agreement, July 1985.

This internal memorandum outlines an agreement between the Environmental Protection Agency and BHCDA which offers migrant health centers consultation and laboratory services on health effects on the farmworker population related to hazardous exposures to pesticides and lead. Highlights of the agreement include a toll-free, 24-hour hotline for diagnostic and treatment consultation on pesticide poisoning; laboratory services on request for confirmation of pesticide poisoning and determination of blood lead levels; training of migrant health center medical personnel on pesticide exposure management, lead exposure management, and other related topics; and profiles by geographic area of major local crops and pesticide utilization.

U.S. General Accounting Office, Human Resources Division. *Administration on Aging: More Federal Action Needed to Promote Service Coordination for the Elderly*. Washington, DC: General Accounting Office, 1991.

The purpose of this report to the Subcommittee on Aging in the U.S. Senate and to the Subcommittee on Human Services in the U.S. House of Representatives is to inform Congress on the status of Administration on Aging coordination efforts as it deliberates reauthorization of the Older Americans Act. The report reviews operations regarding activities central to promoting coordination which involved (1) technical assistance to state and local governments, and (2) dissemination of information from research and demonstration projects. Also examined was information on varying state experiences in coordinating services.

U.S. General Accounting Office, Human Resources Division. *Special Education: Financing Health and Educational Services for Handicapped Children* Washington, DC: General Accounting Office, July 1986.

This briefing report from the GAO includes a number of valuable items. First are sample interagency agreements from Connecticut and Maryland, including agreements for a third-party billing system and an interagency cost-sharing arrangement. The Maryland interagency agreement discussed the formation of local and state councils, addressing how the process works as well as the current status and impact of the project Second is a briefing on state views on interagency agreements which emphasizes the necessity for sufficient authority, commitment by agency officials, sufficient planning, and the commitment of needed resources. Also included is draft legislative language which clarifies the financial responsibility for services required under Public Law 94-142, requiring the cooperation of agencies as a state goal, encouraging the development of interagency agreements, and discussing the use of Medicaid funds for educationally related health services required in an individual education plan. Finally, comments by the U.S. Departments of Health and Human Services and Education are appended.

U.S. House of Representatives, Committee on Agriculture and Committee on Science, Space, and Technology. *Nutrition Monitoring.* Washington, DC: Congressional Information Service, September 21, 1989.

This document records the proceedings of a joint hearing before the Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition, the Subcommittee on Department Operations, Research, and Foreign Agriculture, and the Science, Space, and Technology Committee Subcommittee on Science, Research, and Technology to review nutrition monitoring and research activities of the Departments of Health and Human Services and Agriculture. The hearing also considered H.R. 677, the National Nutrition Monitoring and Related Research Act, and the related H.R. 1608, the Comprehensive National Nutrition Monitoring System Act, which would establish a coordinated program of nutrition monitoring and related research on dietary needs, food consumption, and health relationships.

Included in the supplementary material are witnesses' prepared statements, submitted statements and correspondence. Among the witnesses were Dr. J. Michael McGinnis, Deputy Assistant Secretary for Health, Disease Prevention and Health Promotion, and Ann Chadwick, Acting Assistant Secretary, Food and *Consumer Services,* who provided an overview of HHS and USDA nutrition monitoring activities, including interagency coordination. In addition, representatives from the University of Minnesota, Association of State and Territorial Public Health Nutrition Directors, and National Cattlemen's Association testified about the need for legislation to establish coordinated nutrition monitoring and research programs.

U.S. House of Representatives, Committee on Education and Labor. *Oversight Hearing on Interagency Coopemtion*. Washington, DC: Congressional Information Service, March 23, 1984.

This document reports the proceedings of a hearing in Aliquippa, Pennsylvania before the Select Subcommittee on Education to review public education for handicapped children in Pennsylvania. The hearing focused on cooperation among federal, state, and local mental retardation and education authorities for special education programs. Supplementary material (p. 40-68) includes submitted statements, witnesses' written statements, correspondence, and readings.

University of North Carolina at Chapel Hill, Department of Maternal and Child Health. *Improving the Health of Migrant Mothers and Children, Interim Report*. Chapel Hill: University of North Carolina, February 1986.

This report summarizes the progress of a demonstration project administered by the University of North Carolina at Tri-County Community Health Clinic in Newton Grove, NC. The project objectives were 1) to assess the health and nutritional status of pregnant women and children- aged O-5 years and to institute interventions for identified health problems, 2) to determine how environmental conditions, lack of financial and social resources, and barriers to access to care influence the health status of migrant mothers and children, 3) to develop model protocols and a data collection and reporting system, 4) to implement a continuous system of provision of care which would utilize and link resources of state end local agencies and migrant health centers in North Carolina and Florida, 5) to demonstrate the effectiveness of lay health advisors for disseminating information to migrant workers and linking them with health *services*, and *6) to* develop educational modules and materials based on the realities of the migrant lifestyle.

The project was planned as a collaborative effort between the health center, the university, and the state department of human resources. The interim report describes project activities and methods as of February 1986, and outlines the working relationships and division of responsibilities among the participating agencies.

Van Dyck, Peter; et al. *Creating an Information Base for Program Collaboration. Workbook Series for Providing Services to Children with Handicaps and Their Families.* Washington, DC: Georgetown University Child Development Center, 1984.

This publication describes Utah's Handicapped Child Data Project, an interagency effort to share information among agencies dealing with developmentally disabled persons and to establish a central registry. Five action steps in such a venture are noted, including identifying potential sources of information on state and individual levels, decreasing the use of jargon, signing agreements of understanding, and implementing an automated central data system. Three

stages of information exchange are described and component steps reviewed: gathering information about an individual child, establishing program to program or agency to agency communication, and building a statewide system. The efforts of the Handicapped Child Data Project are reviewed in terms of history, organization, policies, and sample data screens.

Waldman, Risa J. *Computerized Coordinated Service Center A Comparison of Service Methodologies and Costs in the Urban and Rural Area.* Bridgeport, CT: Center for Independent Living of Greater Bridgeport, 1983.

Ten parallel human service agencies (five urban and five rural) were compared to identify variations in the service delivery system and to compare the costs of service provision. The agencies responded to approximately 36 questions covering eight major areas and were compared and contrasted, urban versus rural, according to the type of agency. All of the agencies used some form of basic media advertising but felt more marketing was required. All participated in two or more multi-agency collaborative efforts, with the urban agencies generally involved in more such efforts. Advantages were reduction of duplication and utilization of participating agency strengths. Disadvantages were problems in dealing with conflicting personalities and loss of flexibility and control over programs. All agencies were aware of other services for individuals ineligible for their programs and were satisfied with the number of referrals they made and received. The largest differences were found in their identification of priorities due to service gaps and future plans to address them. (These need areas are discussed in detail in five sections, which compare and contrast the 10 agencies by type of service offered. A table provides information regarding service fees, who determines rates, annual operating budgets, and total revenue generated.)

Washington Office of the State Superintendent of Public Instruction, Division of Special Services and Professional Programs. *Partnerships for the Future: Proceedings.* Olympia, WA: Office of the Superintendent of Public Instruction, 1987.

These proceedings are the outcome of a two-day conference involving education, health, and human service providers who work with children and youth with handicapping conditions across Washington State. The conference's purpose was to bring representatives from interagency teams together to exchange information about how the interagency teams operate, exchange information about barriers/issues related to interagency coordination, participate in staff development on the maintenance of effective interagency coordination and transition, and discuss the commitment both state agencies and local communities have to interagency coordination. Reports are presented from interagency teams focusing on specific program areas, including early childhood, seriously behaviorally disabled, and transition. Each report describes the activities of several interagency teams; the benefits of interagency collaboration to the public, families of handicapped children, and agencies/providers; and key issues. Appendices contain a list of participants, biographical information about con-

ference facilitators and presenters, conference worksheets, an interagency agreement between the Washington State Department of Social and Health Services and the Office of the Superintendent of Public Instruction, eligibility criteria for handicapped students, and conference evaluation results.

Wasman, Nancy. *Evaluation of the Dade-Monroe Multiagency Network for Severely Emotionally Disturbed Students. Miami, FL:* Dade County Public Schools, Office of Educational Accountability, 1985.

The evaluation report examines the Dade-Monroe Multiagency Network for Severely Emotionally Disturbed (SED) Students, a 3-year regional (Florida) project to improve education, mental health treatment, and residential services for this population. The program's main components-a regional case management system, a computerized information system, and an interagency council—were designed to address three major state mandated goals: provision of a complete array of services to SED students; improvement of existing services; and continuous multiagency plarming, implementation, and evaluation of services. Evaluation methodology included survey instruments, interviews, and examination of relevant records/documents. Major findings of the evaluation included the following: an increase in the numbers of students identified as SED though fewer services per student were provided; improvement in communication, coordination, and cooperation among school programs and agencies; no improvement in the time interval before a student begins receiving services; improvement in the flow of information and implementation of the computerized information system; and provision of case management services by Network staff. Among recommendations are continuation of the project, increased funding levels, and provision of in-service training to agency staff. Appendices include the school/agency survey instrument and the interagency council interview form.

Wenger, Marta; et al. *Physician Involvement in Planning for P.L. 99-457 Part H: Interagency Coordinating Council Roles and System Planning Issues.* Chapel Hill, NC: University of North Carolina at Chapel Hill, Carolina Institute for Child and Family Policy, 1989.

The results of a survey of physicians actively involved at the state level in policy development for Part H of Public Law 99-457 are reported. A questionnaire was completed by a total of 125 physicians, including physicians identified as Interagency Coordinating Council (ICC) members and physicians who served as state chapter representatives to the American Academy of Pediatrics conference on Public Law 99-457. Examined are the roles physicians have taken in state planning for early intervention services for infants and toddlers with developmental delays, their attitudes toward the eligibility of at-risk children under Part H, their assessment of the relationship between the private health sector and the public human service system, and their perspectives on the major barriers to implementation. Findings included, among others, that six states had no physicians involved in the work of their ICCs; that there was strong

consensus in favor of broad-based eligibility criteria; and that physicians reported modest improvement in the relationship between the private health care sector and the public human service system since enactment of the law. Policy implications are outlined.

Williams, Rick L.; et al, *Study of WIC Participant and Program Characteristics, 1988: Final Report. Volume 1, Summary of Findings.* Repared by Research Triangle Institute. Alexandria, VA : U.S. Department of Agriculture. Food and Nutrition Service, 1990.

This report summarizes methods end results of a study of the Special Supplemental Food Rogram for Women, Infants and Children (WIC), a federal nutrition assistance program. The survey was designed to provide the information needed to develop a comprehensive database on WIC administrative and participant characteristics. All data collection occurred between March and August 1988 and consisted of three surveys, a state agency survey, a local agency survey, and a participant survey. The report describes the program, characteristics of the agencies and participants, food package contents, and patterns of participation.

Wolfe, Rosalie S. 'Model for the Integration of Community-Based Health and Social Services." Paper presented at the Annual Scientific Meeting of the Gerontological Society, San Francisco, CA, November 17-22, 1983.

Practitioners, researchers, and policy makers have attempted to improve the delivery of in-home services to the frail elderly through the expansion or merger of existing care providers or through the creation of coordinating units. To investigate the feasibility and effectiveness of a third approach to in-home services, 63 older adults with maintenance health care or social needs participated over a $-month period in the Integrated Continuing Care Rogram (ICCP), in Worcester, Massachusetts. The ICCP provided coordinated assessment, care planning, case management, homemaker-home health aide, and senior companion services to an experimental group of adults through interagency cooperation. A control group of adults received services through a traditional; non-integrated approach. An analysis of the results showed no significant differences between the two groups in sociodemographic characteristics, number of impairments, problems in activities of daily living, amount of medication, emotional status, or length of stay in the program. The ICCP proved to be a viable model, both in units and costs of services provided. Those clients who were provided with integrated services used 13.0 hours of homemaker assistance and 13.9 hours of home health care per month, while the control group used 27.2 hours of homemaker help and 5.7 hours of home health care. The experimental clients averaged $291.37 per month for all indirect and direct services, a 12 percent saving; the control group clients averaged $325.89 per month.

Woodruff, Geneva and Sterzin, Elaine Durkot. "Transagency Approach: A Model for Serving Children with HIV Infection and Their Families," *Children Today: May-June* 1988, pp. 9-14.

> This article discusses the goals and organization of a Boston-based Project WIN which was created in 1986 to respond to the challenge of providing services for IV drug-using families and their children who have been diagnosed with AIDS, AIDS Belated Complex, or HIV infection. The project uses a case management system designed to coordinate services for families who are involved with multiple agencies with the purpose of avoiding duplication of services, cutting down on costs and confusion, and reducing conflicting and competing expectations often experienced by families when agencies serving them work in isolation.

Woy, J. Richard and Dellario, Donald J. "Issues in the Linkage and Integration of Treatment and Rehabilitation Services for Chronically Mentally Ill Persons." ***Administration in Mental Health*** 12(3): Spring 1985, pp. 155-65.

> This article compares and contrasts characteristics of the mental health system and the Vocational Rehabilitation (VR) service system. It examines environmental, intra-organizational, and inter-organizational variables as they pertain to potential for linkages between mental health and VR providers, and discusses implications for improved integration of treatment and rehabilitation services for chronically mentally ill persons.

Zyrkowski, Collette. "Description of WIC/MCH Activities in Illinois, Michigan, and Ohio." Chicago: U.S. Department of Health and Human Services, undated.

> This document is a report by the DHHS regional MCH nutrition consultant on maternal and child health activities of the Special Supplemental Food Program for Women, Infants and Children (WIC). The report provides an overview of the number of agencies supplying WIC services in each state, monthly participation figures, and organizational structure, and strengths and limitations of the state WIC program. Included in this assessment is a commentary on referrals between WIC and other health services, and on coordination between WIC agencies and other maternal and child health programs. The report is strictly a descriptive document, and does not propose any action toward addressing limitations identified by the assessment.

APPENDICES

Appendix 1

Migrant Health Center Candidates for Case Study

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Integration and Coordination of Services at Migrant Health Centers as of March 1990

Migrant Health Center Candidates for Case Study

Criietia	Plan de Saiud del Vaiie Colorado	Migrant and Rural Community Health Assoc. Michigan	Keystone Migrant Health (Pennsylvania Farmworker Opportunities, inc.) Pennsylvania	Tri-County Community Health Center North Cardina	iiiinds Migrant Coundi iiiinds
Type of program to be evaluated	dental, environmental, Head Start	Project NOMAD and Migrant Education	STD, TB, dental	substance abuse, perinatal: Newton Grove	nursing assessment and referral network
Geographic representation	midwest, upstream	midwest, upstream	east, upstream	east, upstream	midwest, upstream
Non-traditional alliances	yes	yes	yes, with dentist volunteers and labor programs	yes, with growers	yes, TTPA, Legal Aid, Loyola School of Dentistry
Local, state, or multi-state program	local	local	local	local	state
Size and complexity of organization	$6 million	$3 million	$169,009	$1.1 million	$500,000
Number of users eerved	24,669		7-800	5,500	3,060 medical/1,700 dental
Documentation of formal agreement	yes	yes	yes	yes, with mental health center	yes
Funding type	329/330	329/330	329 only	329/330	329 only
Service delivery model	comprehensive	one of each	comprehensive	comprehensive	nursing voucher
Recommended by regional office	yes		yes	yes	yes
Recommended by primary care association	yes		yes	yes	yes
Initiator of coordinated service	migrant health	migrant health	migrant health	migrant health	migrant health
Other agencies involved		HHS, Head Start, tertiary hospital linkage, seasonal physician recruitment	state health dept., county Migrant Education, private dentists	health dept., social services, Campbell & Duke Universities	Dept. of Education, Head Start, informal vocational rehabilitation
Time in operation	20 years (dental), 12 (Head Start), 6 (environ.)		3 years	14 years	7 years
Number of sites	7	5	1	1	6
Willing to participate	yes	yes	yes	not during migrant season	yes

Migrant Health Center Candidates for Case Study

Criteria	La Clínica del Cariño Oregon	El Progreso del Desierto California	Yakima Valley Farmworkers Clinic, Inc. Washington	Collier Health Services, Inc. Florida
Type of program	OB, outreach, home visits, perinatal: Hood River	AIDS Consortium: testing, out-patient, education	mental health, drug and alcohol abuse services	Hospital linkages and health professions training
Geographic representation.	west, upstream	west, downstream	west, upstream	east, downstream
Non-traditional alliances	no	no	yes	yes
Local, state, or multi-state program	local	local	local	local
Size and complexity of organization	$1,014,575	$200,000	$16 million	
Number of users served	3,943		47,ooo	
Documentation of formal agreement	yes	yes	yes	yes
Funding type	329/330	329/330	329'330	329/330
Service delivery model	comprehensive	comprehensive	comprehensive	comprehensive
Recommended by regional office	yes	yes	yes	
Recommended by primary care association	yes	yes	ye5	
Initiator of coordinated service	migrant health	other	migrant health	
Other agencies involved	county health depts., adult & family services, Oregon Health Services University	hospitals, county MCH dept., El Progreso Desert AIDS Project	Catholic Family Children's Society, comprehensive mental health	
Time in operation	5.5 years	2 years	4 years (substance abuse starting April 1991)	
Number of sites	1	3	6 medical/dental, 4 mental health	
Willing to participate	yes	yes	yes	yes

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region I

Grantee	Episodic/ Chronic Medical	Primary Prevention	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environmental Health	Comments
New England Farmworkers Coundl Springfield, MA	◊	◊	◊	◊	◊	◊	◊	◊	◊	◊	

● Service provided directly by clinic providers

◊ Service provided by referral to other provider(s)

♦ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region II

Grantee	Episodic/ Chronic Medical	Primary Prevention	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	outreach/ Transport	Environmental Health	Comments
Bridgeton Area Health Services Bridgeton, NJ	◊ ◊	◊ ◊	◊	●		●	●	●		◊	
Sa-Lantic Health Services, inc. Hammonton, NJ	●	◊ ◊	◊ ♦		●		◊	●			
Hudson Valley Migrant Health/Peekskill Area Health Center Peekskiii, NY	●	●	●	●	●		♦ ◊	●		♦ ♦	
Oak Orchard Community Health Center Brockport, NY	●	●	●	●	◊	◊ ◊	●		●	◊	
Sodus Health Center Sodus, NY	◊ ◊	◊ ◊	◊	●		●	●		●	◊	
Castañer General Hospital, inc. Castañer, PA	●	●	●	♦	●	●	●	●	●	♦	
Conciiio de Salud integral de Loiza, inc. Loiza, PR	●	●	●	●	●	●	●	●		◊	
Corporación de Servicios de Salud a Migrantes Agricola Ciira. PR	●	●	●	●	●	♦	♦	●	●	●	
Corporación de Servidos de Salud Integrales de la Montaña Naranjito, PR	●	●	●	●	●	●	●	●	●	●	

● Service provided directly by clinic providers

◊ Service provided by referral to other provider(s)

♦ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region II

Grantee	Episodic/ Chronic Medical	Primary Preven- tion	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environ- mental Health	Comments
Diagnostic and Treatment Center of la Playa de Ponce, Inc. Playa de Ponce, PR	◊	•	●	●	●	●	●	●	•	◊	
Migrant Health Program Western Region, Inc. Mayaguez, PR	◊	●	●	●	.	♦	0	●	•	◊	
Primary Health Services Center Patillas, Inc. Patillas, PR	●	●	♦	♦	●	●	●	●	●	●	

● Service provided directly by clinic providers

◊ Service provided by referral to other provider(s)

♦ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region III

Grantee	Episodic/ Chronic Medical	Primary Prevention	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environmental Health	Comments
Delmarva Rural Ministries Dover, DE	◊ ◆	◆	◆		●		◆ 0	●	●		◆	
Pennsylvania Rural Opportunities Camp Hill, PA	●	●	●	●	◆	●	●	●	●	●	a	
Benton, Medical Community Corp. Benton TN	◊	●	●	◊	◊	●	●	●	●	●	●	
Rural Health Services Consortium of Upper East Tennessee, Inc. Rogersville, TN	◊	0	◊	0	◆	◆	◊	◆	◆			
Shenandoah Community Health Center Martinsburg, WV	●	◊	◊	0	◊	●	◊	●	●	●		

● Service provided directly by clinic providers

◊ Service provided by referral to other provider(s)

◆ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region IV

Grantee	Episodic/ Chronic Medical	Primary Preven- tion	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environ- mental Health	Comments
Collier Health Services, Inc. Immokalee, FL	◊	●	●	●	●	●	●	●	●	◊	
Community Health Centers, Inc. Apopka, FL	♦	●	●	♦	●	♦	♦	●	●	◊	
Community Health of South Dade, Inc. Miami, FL	●	●	♦	♦	●	●	●	●	●	●	
East Pasco Health Center, Inc. Dade City, FL	●	●	●	♦	♦	♦	◊	♦	♦	◊	
Family Medical and Dental Center Palatka, FL	●	●	♦	♦	♦	♦	♦	●	♦		
Florida Community Health Center, Inc. West Palm Beach, FL	●	●	●	●	●	●	●	●	●	◊	
Florida Rural Health Services, Inc. Avon Park, FL	◊	●	●	●	●	●	●	●	♦	◊	
Gadsden Primary Care Center Quincy, FL	◊				●	●	◊	♦		◊	
HRS Palm Beach County Public Health Unit West Palm Beach, FL	●	●	●	♦	●	●	♦	●	♦	●	

● Service provided directly by clinic providers

◊ Service provided by referral to other provider(s)

♦ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region IV

Grantee	Episodic/ Chronic Medical	Primary Prevention	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environmental Health	Comments
Manatee County Rural Health Services, Inc. Parrish, FL	●	●	●	●	●	◊	◊	●	●	◊	
Ruskin Migrant and Community Health Center, Inc. Ruskin, FL	◆	●	◆	◆	●		◆ ◆ ◆		●	◊	
Southwest Florida Health Centers y Clinicas de Migrantes Fort Myers, FL	●	●	●	●	●	●	◆	●	●	◊	
Migrant Health Program Metter, GA	●	●		●	◆	◆	◆	●	●	●	
Blue Ridge Health Center Hendersonville, NC	●	●	●	●	●	●	●	●	●	●	
Goshen Medical Center Faison, NC	●	◊	v	◊ ◊	.	● ●	◆			●	
Migrant Health Program/North Carolina Dept. of Environment, Health, and Natural Resources Raleigh, NC											
Tri-County Community Health Center Newton Grove, NC	●	●	●	●	●	●	●	●	●	●	

● Service provided directly by clinic providers

0 Service provided by referral to other provider(s)

◆ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region IV

Grantee	Episodic/ Chronic Medical	Primary Preven- tion	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environ- mental Health	Comments
Franklin C. Fetter Family Health Center, Inc. Charleston, SC	●	●	●	●	●	●	●	●	◊		
MEGALS Rural Health Association, Inc. Trenton, SC	♦	●	●	●	●	♦	♦	●	♦	◊	
Migrant Health Project/South Carolina Dept. of Health end Environmental Control Columbia, SC	●	●	●	●	♦	♦	♦	●	●	◊	

● Service provided directly by clinic providers

◊ Service provided by referral to other provider(s)

♦ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region V

Grantee	Episodic/ Chronic Medical	Primary Preven- tion	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Educetlon	Outreach/ Transport	Environ- mental Health	Comments
Illinois Migrant Council Chkago, IL	●	●	◊	♦	♦	♦	. ●		●	♦	
Shawnee Health Service and Development Corp. Murphysboro, IL	●	●	.	♦	♦	♦	◊	●	.	●	
Indiana Health Centers, Inc. Indianapolis, IN	●	●	◊	♦	●	a	◊	●	●	●	
Health Delivery, Inc. Saginaw, MI	●	●	●	●	◊	◊	0	.	●	♦	
Migrant and Rural Community Health Association (MARCHA) Bangor, MI	●	●	.	4	4	●	0	.	●	4	
Northwest Michigan Health Services Traverse City, MI	0	4	●	4	4	4	0	●	●	●	
Pullman Health Systems Pullman, MI	●	●	●	●	●	●	0	●	●	●	
Sparta Health Center Sparta, MI	●	●	4	4	4	.	.	●	4	4	
Migrant Health Service, Inc. Moorhead. MN	●	4	4	4	4	4	4	●	●	●	

● Service provided directly by clinic providers

0 Service provided by referral to other provider(s)

4 Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region V

Grantee	Episodic/ Chronic Medical	Primary Preven- tion	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environ- mental Health	Comments
Community Health Services Fremont, OH	●	●	●	●	●	●	◊	●	●	◊	
FHS Medical Center Greenville, OH	●	◊	◊	◊	◊	●	◊	●	●	◊	
Family Health/La Clinica (La Clinica de los Campesinos, Inc.) Wild Rose, WI	●	●	♦	♦	●	♦	◊	●	●	●	

● Service provided directly by clinic providers

0 Service provided by referral to other provider(s)

♦ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region VI

Grantee	Episodic/ Chronic Medical	Primaty Preven- tion	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	outreach/ Transport	Environ- mental Health	Comments
La Clinica de Familia San Miguel, NM	◊	●	●	●	●	♦	●	●	0	0	
Barrio Comprehensive Family Health Care Center San Antonio, TX	a	●	●	●	●	♦	♦	. ●		0	
Brownsville Community Health Center Brownsville, TX	0	●	4	4 ●	●		●	●		●	
Community Action Coundl of South Texas Rio Grande City, TX	●	●	●	●	●	●	●	●	◊	●	
Cross Timbers Health Clinic, Inc. DeLeon, TX	●		♦ 0	♦ ♦	♦ ◊		●	●		0	
Hidalgo County Health Care Corp. Pharr, TX	◊	● ♦	♦	●		● ●	●	●		●	
Laredo-Webb County Migrant/UHI Program, Inc. Laredo, TX	●	●	●	●	●	♦ ♦	●	●		●	
South Plains Health Provider Organization, Inc. Plainview, TX	●	●	●	●	♦	♦	♦	●	◊	◊	

● Service provided directly by clinic providers

0 Service provided by referral to other provider(s)

4 Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region VI

Grantee	Episodic/ Chronic Medical	Primaty Preven- tion	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environ- mental Health	Comments
South Plains Rural Health Services, Inc. Levelland, TX	●	◆		●	◆	●	◆	◆	●	◆	
South Texas Rural Health Services, Inc. Cotulla, TX	◆	●	●		◆	◆ ●		●	●	● ◆	
Su Clinica Familiar Harlingen, TX	●	●	●	●	●	●	●	●	●	V	
United Medical Centers Eagle Pass, TX	●	●	●	●	●	●	●	●	●	●	
Uvalde County Clinic, Inc. Uvalde, TX	V	.	V ◆		●	.	V	●	◊	V	
Vida y Salud — Health System, Inc. Crystal City, TX	●	●	●	●	●	◆	●	●	●	●	

● Service provided directly by clinic providers

◊ Service provided by referral to other provider(s)

◆ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region VII

Grantee	Episodic/ Chronic Medical	Primary Preven- tion	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	outreach/ Transport	Environ- mental Health	Comments
proteus Employment Opportunities Des Moines, IA											
Kansas City Wyandotte County Health Dept. Kansas City, KS	●	●	♦	♦	♦ ♦ 0	●		●		●	
Kansas Dept. of Health and Environment Topeka, KS	♦	● ◊	♦		●		● ●	●	♦	0	
New Madrid County Group Practice New Madrid, MO	●	●	0		0	●	●	0	♦	0	
Migrant Health Program/Nebraska state Dept. of Health Lincoln, NE	●	●	●	●	0 0	0 ●		●		.	

● Service provided directly by clinic providers

0 Service provided by referral to other provider(s)

♦ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region VIII

Grantee	Episodic/ Chronic Medical	Primary Preven- tion	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environ- mental Health	Comments
Migrant Health Program/Colorado Dept. of Health Denver, CO	●	◆	◆	◆	◊	●	●	◆	●	◊	
Plan de Salud del Valle, Inc. Fort Lupton, CO	◊	●	●	●	●	●	●	●	●	●	
Sunrise Community Health Center Greeley, CO	●	●	●	●	◊	●	0	●	●	◊	
Valley-Wide Health Services, Inc. Alamosa, CO	●	●	●	●	●	●	0	●	●	●	
Migrant Health Project/Montana Migrant Council Billings, MT	◊	◆	◊	◆	◊	0	0	●	●	◆	
Salt Lake Community Health Centers Salt Lake City, UT											
Goshen-Platte County Migrant Health Project Guernsey, WY	◊	●	◊	◆	◊	0	0	●	●	◊	
Northwest Community Action Programs of Wyoming, Inc. (NOWCAP) Worland, WY	0	0	0	◊	◊	◆	0	●	●	0	

● Service provided directly by clinic providers

◊ Service provided by referral to other provider(s)

◆ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region IX

Grantee	Episodic/ Chronic Medical	Primary Prevention	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environmental Health	Comments
Clinica Adelante, Inc. El Mirage, AZ	◊	◊	◊	◊	♦	♦	◊	♦	♦	♦	
Valley Health Center, Inc. Somerton, AZ	●	●	♦	♦	●	♦	◊	0	•	◊	
Agricultural Workers Health Centers Stockton, CA	●	●	●	●	●	●	◊	●	●	●	
Buttonwillow Health Center, Inc. Buttonwillow, CA	0	●	●	●	●	♦	●	●	●	0	
Clinica Sierra Vista Lamont, CA	•	●	●	●	•	●	●	●	●	●	
Clinicas de Salud del Pueblo Brawley, CA	●	●	●	♦	♦	♦	♦	●	●	●	
Clinicas del Camino Real, inc. Camarillo, CA	♦	♦	0	♦	♦	♦	♦	•	●	●	
El Progreso del Desierto, Inc. Coachella, CA	◊	•	•	●	●	●	●	●	●	0	
Madera Family Health Center Madera, CA	0	4	0	♦	♦	♦	◊	●			

● Service provided directly by clinic providers

0 Service provided by referral to other provider(s)

♦ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region IX

Grantee	Episodic/ Chronic Medical	Primary Prevention	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environmental Health	Comments
Merced Family Health Centers, Inc. Merced, CA	♦	♦	●	♦	●	♦	◊	●		0	
Nipomo Community Medical Center Nipomo, CA	◊	●	●	●	●	●	●	●	●	◊	
North County Health Services San Marcos, CA	●	●	●	●	●	●	●	●		●	
Northern Sacramento Valley Rural Health Project Olivehurst, CA	●	♦	●	♦	♦	●	●	♦	◊	♦	
Porterville Family Health Center Porterville, CA	●	0	0	0	●	●	◊	●	●	●	
Sequoia Community Health Foundation Fresno, CA	●	0	◊	◊	●	●	●	●	♦	♦	
United Health Centers of San Joaquin Valley, Inc. Parlier, CA	●	●	●	♦	●	●	●	●	♦		

● Service provided directly by clinic providers

0 Service provided by referral to other provider(s)

♦ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region X

Grantee	Episodic/ Chronic Medical	Primary Preven- tion	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environ- mental Health	Comments
Family Health Services Corp. Twin Falls, ID	◊	●	◊	♦	♦	♦	0	♦	●	◊	
Valley Family Health Care Payette, ID	0	0	0	♦	♦	♦	•	●	♦	◊	
La Clinica del Cariño Family Health Care Canter. Inc. Hood River, OR	0	♦	0	♦	♦	♦	0	♦	●	•	
La Clinica del Valle Phoenix, OR	0	●	0	♦	●	●	0	●	●	♦	
Salud Medical Center, Inc. Woodburn, OR	●	●	●	•	•	●	●	●	●	◊	
Virginia Garcia Memorial Health Center Cornelius, OR	◊	◊	◊	◊	•	●	◊	●	●	◊	
La Clinica Migrant Health Center Pasco, WA	◊	●	●	●	◊	♦	0	•	●	•	
North Central Washington Migrant Health Project Wenatchee, WA	●	●	●	●	●	●	0	•			
Okanogan Farmworkers Clinic Okanogan WA	●	♦	◊	♦	♦	●	•	•	●	•	

● Service provided directly by clinic providers

0 Service provided by referral to other provider(s)

♦ Service provided both directly and by referral

Integration and Coordination of Services at Migrant Health Centers as of March 1990

Region X

Grantee	Episodic/ Chronic Medical	Primary Preven- tion	WIC	Dental	Pharmacy	Lab	X-Ray	Nutrition/ Health Education	Outreach/ Transport	Environ- mental Health	Comments
Sea Mar Community Health Center Seattle, WA	●	●	♦	♦	●	●	●	●	♦	◊	
Yakima Valley Farmworkers Clinic Toppenish, WA	●	●	●	●	●	♦	♦	●	●	◊	

● Service provided directly by clinic providers

0 Service provided by referral to other provider(s)

♦ Service provided both directly and by referral

Appendix 2

Site Profiles

Collier Health Services
Immokalee, Florida

Major Components Evaluated:	Impact/Benefits:
Coordination with Community Hospital	❑ For Clinic Users-Patients are able to receive all the referrals they need at no cost or reduced cost. ❑ For Health Center-Collier has affordable access to the laboratory tests necessary for diagnosis and treatment. ❑ For Other Agency(ies)-In making the trip to Immokalee for Collier's laboratory business, the hospital's lab also gains access to smaller providers in that part of the county.
Coordination with Medical School	❑ For Clinic Users-Availability of residents and students increases staffing of the health center, allowing Collier to provide better health care to its user population. ❑ For Health Center-The association with the medical school provides professional contacts, stimulation, and resources for Collier medical staff, thereby overcoming some of the disadvantages of the clinic's remote location and improving staff retention. ❑ For Other Agency(ies)—Collier provides an excellent educational opportunity for medical students, with a varied and demanding caseload and a staff that helps students feel comfortable in the community.

El Progreso del Desierto, Inc.
Coachella, California

Major Components Evaluated:

HIV Services

Impact/Benefits:

- For Clinic Users-Through the AIDS Consortium, El Progreso increases access to high quality, coordinated health care for persons who are HIV-infected.
- For Health Center-Coordination with other agencies provides additional services and health education resources for the patient population served by El Progreso.
- For Other Agency(ies)--El Progreso serves as a resource to other members of the Consortium by serving Spanish-speaking clients.

Integration and Coordination of Services in Migrant Health Centers
SITE PROFILE

Illinois Migrant Council
Chicago, Illinois

Major Components Evaluated:	Impact/Benefits:
Relationship with McHenry County Health Department	0 For Clinic Users-Patients receive improved access to care, better continuity of care, available of a more comprehensive set of eervicee, personalized guidance through what might otherwise be a maze of providers, and assurance that the care provided will be relevant to their linguistic and occupational needs. 0 For Health Center-IMC is able to leverage care far beyond what would otherwise be available and to tap a diverse eet of professional skills which would not otherwise be available for a small and isolated population. 0 For Other Agency(ies)-The health department is able to demonstrate its commitment to serve all patients in the area, without bias regarding residence, occupation, or ethnicity.
Integration of Services with Private Practitioner	0 For Clinic Users-Farmworkers have the opportunity to access care as equals in the community mainstream, and to exercise responsibility for their own individual care. ❑ For Health Center-By using local resources to provide care, IMC eliminates the need to import health professionals solely to care for farmworkers, and also sensitizes private providers to migrant health issues. ❑ For Other Agency(ies)--Private practitioners are given the ability to make a contribution to a working indigent population, while being freed from the maze of paperwork which usually plagues those who provide care to the indigent.

Integration and Coordination of Services in Migrant Health Centers
SITE PROFILE

Keystone Migrant Health
Chambersburg, Pennsylvania

Major Components Evaluated:

Coordinated Dental Program

Impact/Benefits:

- **For Clinic Users-Keystone's patients receive access to much-needed dental care.**
- **For Health Center-The clinic is able to capitalize upon resources which expand the volume and quality of services well beyond what would be possible with only federal dollars.**
- **For Other Agency(ies)-The volunteer dentists reap personal and professional awards from participation, resulting in a stronger network of dental professionals and cross-pollination between the medical and dental communities.**

La Clínica del Cariño
Hood River, Oregon

Major Components Evaluated:

Perinatal Service Components

Impact/Benefits:

- For Clinic Users-Perinatal clients are offered comprehensive, case-managed perinatal and postpartum services.
- For Health Center-Through close working relationships with many different agencies, the clinic has expanded the services it can offer and provided leadership for a county-wide perinatal service delivery initiative.
- For Other Agency(&)-The clinic's highly trained providers represent a resource for referral of specialized health care services such as child abuse exams and high-risk obstetrical procedures.

integration and Coordination of Services in Migrant Health Centers
SITE PROFILE

Migrant and Rural Community Health Association (MARCHA)
Bangor, Michigan

Major Components Evaluated:

Project NOMAD

Impact/Benefits:

- For Clinic Users-Coordination between the school and the clinic improves the continuity of health care provided to the clinic users.
- For Health Center-The health center is able to use nursing personnel to perform triage and handle most patient encounters off-site, reducing the load on clinic staff and higher-level providers.
- For Other Agency(ies)-Project NOMAD conserves its financial resources by reducing the number of patients who must be sent to private providers at NOMAD's expense.

Integration and Coordination of Services in Migrant Health Centers
SITE PROFILE

Plan de Salud del Valle, Inc.
Fort Lupton, Colorado

Major Components Evaluated:	Impact/Benefits:
Environmental Health Services	0 For Clinic Users-Environmentally hazardous conditions in migrant labor camps are improved.
	0 For Health Center-Staff time spent controlling health hazards in the environmental reduces time spent providing acute medical care.
	0 For Other Agency(ies)-All organizations in the partnership benefit from regional and national credibility for this collaborative effort.
Dental Services	0 For Clinic Users-Comprehensive dental care services are available to migrant families.
	❑ For Health Center-Salud dental staff productivity is enhanced because staff can focus on providing dental services rather than on administrative details.
	0 For Other Agency(ies)-Agencies can provide clients with better dental care than mandated, at substantial savings per child.
Migrant Head Start Health Services	❑ For Clinic Users-Migrant children can stay in school and be treated for illness on-site, so that they do not miss school and parents do not lose income to make a clinic visit.
	0 For Health Center-Having a "captive" population (of school children) reduces staff visits to the Head Start day care site and allows more efficient access to patients.
	❑ For Other Agency(ies)-Working together has established preventive health intervention on behalf of Head Start's migrant children.

Integration and Coordination of Services in Migrant Health Centers
SITE PROFILE

Tri-County Community Health Center
Newton Grove, North Carolina

Major Components Evaluated:

Perinatal Program

Substance Abuse Program

Impact/Benefits:

- For Clinic Users-Better maternal and child health services are provided to farmworkers, resulting in healthier mothers and babies.
- For Health Center—Coordination with counties enables Tri-County to follow its patients through the postpartum period.
- For Other Agency(ies)—Tri-County serve5 as a resource for bilingual/bicultural staff and psychosocial and support services to farmworkers.
- For Clinic Users-Both the quantity and quality of substance abuse services available for farmworkers are increased.
- For Health Center-'W-County's service capabilities are enhanced and the clinic can place emphasis on prevention a5 well as referring patients for whom different levels of service are appropriate.
- For Other Agency(@)-Increased usage of services provided by Tri-County lessens the need for duplicate services by counties, conserving fiscal resources.

Yakima Valley Farmworkers Clinic
Toppenish, Washington

Major Components Evaluated:

Children Family Case Management

Impact/Benefits:

- For Clinic Users-This program provides access to mental health services for Hispanic and other minority populations traditionally not served by other mental health resources in the catchment area.
- For Health Center-Funds received from the county assist the clinic with overhead and further integration of mental health and medical needs for the user population.
- For Other Agency(ies)-School systems and county agencies are able to extend their own mental health services through this program.

School-Based Day Treatment

- For Clinic Users-Farmworker families have access to specialized classroom treatments and services that are otherwise unavailable.
- For Health Center-The clinic gains direct referral from participating school systems, often a first point of contact for students' families.
- For Other Agency(ies)—The program extends the special education capabilities of the participating school systems.

El Centro de Amistad

- For Clinic Users-El Centro provides a sole source of access for adult Hispanic men and women who seek mental health counseling.
- For Health Center-The clinic is able to offer mental health and social services to its Spanish-speaking patients.
- For Other Agency(ies)—County and state departments of social services and other providers in the catchment area have a resource for referrals of Spanish-speaking clients.

Appendix 3

Integration/Coordination of Category 1 Services

and

Integration/Coordination of Category 2 Services

Integration/Coordination of Category 1 Services

Migrant Health Center	Primary Prevention	Episodic/Chronic Medical	Family Planning	OB - Prenatal	OB - Delivery	Outreach	Transportation	Emergency/After Hours	Hospitalization	Pharmacy	Lab	X-Ray	Health Education	WIC	Nutrition Education/Counseling	Emergency Food	Preventive Dental	Diagnostic/Restorative Dental	Emergency Dental	HIV Screening/Counselling	HIV Counseling/Outreach	HIV Treatment
Clinica Adelante (El Mirage, AZ)	1 1 1		2	2		1 3		3	3		1 2	2	1 2	2	3	2		2	2	3	3	3
Valley Health Center (Somerton, AZ)	1	1	1	1	1	1	1	1	1	1	1,2	2	1	1	1	1	1 1	1	1	1		2
Agricultural Workers Health Centers Stockton, CA)	1	1 1		1	1 1		2		1 1	1	1	2	1	1	1 1		3		1	1 1	1	1
Buttonwillow Health Center (Buttonwillow, CA)	1	1	1	1	1	1	1	1	1	1	1	1	1		1	1		1	1	1		
Clinica Sierra Vista (Lamont, CA)	1 1		1		1 2		1		1 3		1 1 1	1	1		1 1		3		1 1 1 1		1	1,3
Clinicas de Salud del Pueblo (Brawley, CA)	1	1	1	1	2	1	1	1,2	2	1	1	1	1	1	1	3	1	1	1	1	1	1
Clinicas del Camino Real (Camarillo, CA)	1 1 1		1	1,2	1	1	1		1 . 2	1,2	1,2	1	1	1,2	1	2,3	1	1 . 2	3	3	1	3
El Progreso del Desierto (Coachella, CA)																						
Madera Family Health Center (Madera, CA)	1	1	1	1	3	1	1, 3	1	1	1,2	1,2	3	13		13		13		3	11		1
Merced Family Health Centers (Merced, CA)	1		1	1		1	11		3	1	1 1 1	1	1	1 1		3		1 1	1	1 1		1
Nipomo Community Medical Center Nipomo, CA)																						
North County Health Services (San Marcos, CA)	1 1 1		2	2		1 3	2		2	1	1	1	1	1	1	1	1	1	1	1	1	1
Northern Sacramento Valley Rural Health Project (Oliverhurst, CA)																						
Porterville Family Health Center (Porterville, CA)	1	1	1	1	1	1	3	2	1	1,2	1,2	1,2	1	1,2	1	3	1,2	1,2	3	1, 3	1 ,3	1, 3
Sequoia Community Health Foundation Fresno, CA)	1			1	1					1	1		1									
United Health Centers of San Joaquin Valley Parlier, CA)																						
Colorado Migrant Health Program (Denver, CO)	1	1	1	1, 2	2	1	1	2		2	2	2	1	2	2	2	1	1	1	2	1	2

1 indicates a direct service which is provided by project staff

2 indicates that the project has a formal arrangement with another entity to provide this service.

3 indicates that the project does not provide the service and that patients are informally referred to another source of care.

Migrant Health Center	Primary Prevention	Episodic/Chronic Medical	Family Planning	OB - Prenatal	OB - Delivery	Outreach	Transportation	Emergency/After Hours	Hospitalization	Pharmacy	Lab	X-Ray	Health Education	WIC	Nutrition Education/Counseling	Emergency Food	Preventive Dental	Diagnostic/Restorative Dental	Emergency Dental	HIV Screening/Counselling	HIV Counseling/Outreach	HIV Treatment
Plan de Salud del Valle (Fort Lupton, CO)																						
Sunrise Community Health Center (Greeley, CO)	1	1	1	1	1,2	1	1	1,2	1	1,2	1,2	3	1	1	1	1	1	1	1	1	1	3
Valley-Wide Health Services (Alamosa, CO)																						
Delmarva Rural Ministries (Dover, DE)																						
Collier Health Services (Immokalee, FL)	1	1	1	1	2	1	1	1,2	2	1	1	1	1	2	1	3	1	1	1	1	1	1
Community Health Centers (Apopka, FL)		1	1	1	1	1	1	1	1	1	2	1	1	2		3	1	1	1	1	1	1,3
Community Health of South Dade (Miami, FL)	1	1	1	1	3	1	1	1	2	1	1	1	1	2	1	2	1	1		1	1	1
Family Health Centers of Southwest Florida (Fort Myers, FL)																						
Family Medical and Dental Centers (Palatka, FL)	1	1	1	2	2	1	1	1	1	1,2	1,2	1,2	1	2	1,2	1	1	1	1	1	1	1
Florida Community Health Center (West Palm Beach, FL)	1	1	1	2	2	1	3	3	1	2	1,2	1,2	3	1	1	3	1	1	2,3	1	1	1
Florida Rural Health Services (Avon Park, FL)	1	1	1	1	1	1	1	1	1	1	1	1	1	3	1	3	1	1	1	1	1	1
Health Resource Alliance of Pasco (Dade City, FL)	1	1	1	1	1	1	1	2	2	1	2	2	1	2	2	2	1	1	1	1	2	2
HRS Palm Beach County Public Health Unit (West Palm Beach, FL)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1
Manatee County Rural Health Services (Parrish, FL)	1	1	1	1	1	1	1	1	1	3	1	3	1,3	2	1	3	1	1	1	1	3	1,3
Gadsden Primary Care Center (Quincy, FL)	1	1	1	1	1	3	3	1	1	3	1	3	3	3	3	3	3	3	3	3	3	3
Ruskin Migrant and Community Health Center (Ruskin, FL)																						
Georgia Migrant Health Program (Atlanta, GA)	1,2	1,2	1,2	1,2	1,2	2	1	1	1,2	1,2	2	1	1	1	1,2	1,2	1,2	1,2	1,2	2	1,2	1,2
Family Health Services Corporation (Twin Falls, ID)	1	1	1	1	1	1	3	2	1	2	2	2	1	2	2	2	2	3	3	1	2	1
Valley Family Health Care (Payette, ID)	1	1	1	1	1	1	1	1	1	2	1	2	1	2	1	2	1	3	3	1	1	2
Community Health Partnership of Illinois (Chicago, IL)	1	2	2	2	2	1	1	2	2	2	1	2	1	2	2	1	1	1	2	3	3	3

1 indicates a direct service which is provided by project staff

2 indicates that the project has a formal arrangement with another entity to provide this service.

3 indicates that the project does not provide the service and that patients are informally referred to another source of care.

Migrant Health Center	Primary Prevention	Episodic/Chronic Medical	Family Planning	OB - Prenatal	OB - Delivery	Outreach	Transportation	Emergency/After Hours	Hospitalization	Pharmacy	Lab	X-Ray	Health Education	WIC	Nutrition Education/Counseling	Emergency Food	Preventive Dental	Diagnostic/Restorative Dental	Emergency Dental	HIV Screening/Counselling	HIV Counseling/Outreach	HIV Treatment
Shawnee Health Service and Development Corporation (Murphysboro, IL)																						
Indiana Health Centers (Indianapolis, IN)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	3	3	1	1	3	1
Proteus Employment Opportunities (Des Moines, IA)	2	2	3	2	2	1	1	2	2	2	2	2	1	2	2	2	2	2	2	2	2	2
Kansas City Wyandotte County Health Dept. (Kansas City, KS)	1	1	1	1	1	1	1	3	3	2	1,2	2	1	1	1	3	1	1	3	1	1	3
Kansas Dept. of Health and Environment (Topeka, KS)	1	1	1	1	2			3	3	1	1	1,2	1	1,2	1	1	2	3	3	1	1	3
Rural Health Centers of Maine (Manchester, ME)	1	1		3	3	1	2	2	2	2	2	2	1	2		2						
Health Delivery Inc. (Saginaw, MI)	1	1	1	1	1	1	3	1	1	1	1	1	1	1	1	3	1	1	1	1	1	3
Migrant and Rural Community Health Association (Bangor, MI)	1	1	1	1,3	2	1	1	1	1	1,3	1,2	2,3	1	1	1	3	1	1	1	1,3	1,3	1,3
Northwest Michigan Health Services (Traverse City, MI)	1	1	1	1	2	1	1	3	3	1	2	2	1	2	1	3	1	1	1	1	3	3
Pullman Health Systems (Pullman, MI)	1	1	1,2	1	2	1	1,2	1,3	2	1,2	1,2	2	1	1	1	2	1	1	1	1	1	1,2
Sparta Health Center (Sparta, MI)																						
Migrant Health Service (Moorhead, MN)	1,3	1,3	1,3	2	2	1	1	3	3	3	3	3	1	1	1	3	1,2	3	1,2	3	3	3
New Madrid County Group Practice Clinic (New Madrid, MO)																						
Montana Migrant Council (Billings, MT)	1	1	1,2	1	2	1	1	3	3	2	2	2	1	1,2	1,2	3	1	3	2	1	1	2
Nebraska State Dept. of Health (Lincoln, NE)	1,2	1,2	2	2	2	1	1	2	1	1,2	1,2	2	1	2	1	2	1	1	1	3	3	3
Bridgeton Area Health Services (Bridgeton, NJ)	1	1	1	2	2	1	1	1	1	1	1	2	1	2	2	2	2	2	2	2	1	1
Sa-Lantic Hoahh Services (Hammonton, NJ)	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	2	2	2	1,2	1,2	1
La Clinics de Familia (San Miguel, NM)	1	1	1	2	2	1	3	3,1	1	1	1,2	2	1	2	1	2	1	1	1,3	2	2	1,3
Hudson Valley Migrant Health (Peekskii, NY)	1,2	1,2	1,3	2	2	1,2	1,2	3	3	2	1,2	2	1	2,3	1	3	1	1	1,2	1,3	1,3	1,3
Oak Orchard Community Health Center (Brockport, NY)	1	1	1	1	1	1	3	2	2	2	2	2	1	1	1	3	1	1	1	1	1	1
Sodus Health Center (Sodus, NY)	1	1	1	1	1	1	1	1	1	2	2	2	1	3	3	3	2		2	3	3	3

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Migrant Health Center	Primary Prevention	Episodic/Chronic Medical	Family Planning	OB - Prenatal	OB - Delivery	Outreach	Transportation	Emergency/After Hours	Hospitalization	Pharmacy	Lab	X-Ray	Health Education	WIC	Nutrition Education/Counseling	Emergency Food	Preventive Dental	Diagnostic/Restorative Dental	Emergency Dental	HIV Screening/Counselling	HIV Counseling/Outreach	HIV Treatment
Blue Ridge Health Center (Hendersonville, NC)	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	3	1	1	1	1
Goshen Medical Center (Faison, NC)	1	1	1	3	3	1	1	1	1	1	1	1	1	2	1	3	2	2	2	1	1	1
North Carolina Dept. of Environment, Health, and Natural Resources (Raleigh, NC)																						
Tri-County Community Health Center (Newton Grove, NC)																						
Community Health Services (Fremont, OH)	1	1	1	2	2	1	3	1,2	2	1	1	2	1	3	1	3	1	1,2	1	1	1	3
FHS Medical Center (Greenville, (OH)																						
La Clinica del Cariño Family Health Care Center (Hood River, OR)	1	1	1	1	1	1	1,3	1	1	1,3	1,3	3	1	2	1	3	1	3	2	2,1	2,1	1
La Clinica del Valle (Phoenix, OR)	1	1	1	1	1	1	1	1	1	1	1,2	1,2	1									
Salud Medical Center (Woodburn, OR)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	3	1	1	1	1	2	2
Virginia Garcia Memorial Health Center (Cornelius, OR)	1	1	1	1	1	1	1	1	1	1	1	2	1	2	1	2	1	2	2	1	1	1
Pennsylvania Rural Opportunities (Camp Hill, PA)	1	1	1	2	3	1	1	2	3	1	2	2	1	2	2		2	2	2	1	1	3
Castañer General Hospital (Castañer, PR)	1	1	1	1	1,2	1	1	1	1	1	1	1	1	1	1	3	1	1	1	1	2	1,3
Concilio de Salud Integral de Loiza (Loiza, PR)	1	1	1	1	2	1	1	1	2	1	1	1	1	1	1	3	1	1	1	1	1	2
Corporación de Servicios de Salud Integrales de la Montaña (Naranjito, PR)	1	1	1	1	2	1	1	1	2	1	1	1	1	1	1	3	1	1	2	1	1	2
Corporación de Servicios de Salud a Migrantes Agrícola (Cidra, PR)	1	1	1	1	2	1	1	2	2	1	2	2	1	1	1	3	1	1	1	1	1	1
Diagnostic and Treatment Center of La Playa de Ponce (Playa de Ponce, PR)																						
Migrant Health Program Western Region (Mayaguez, PR)	1	1	1	1	3	1	1	1	3	1	1	2	1	3	1	3	1	1	1	1	1	3
Primary Health Services Center Patillas (Patillas, PR)	1	1	1	1	2	1	1	2	2	1	1	1	1	1	1		1	1	1	1	1	2
Franklin C. Fetter Family Health Center (Charleston, SC)																						

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MEGALS Rural Health Association (Trenton, SC)	1	1	1	1,2	2	I	1	2	3	1,2	I	1	1	1	1	3	3	3	1	1	1	1
Office of Rural Health, Migrant Health, and Primary Care (Columbia, SC)																						
Benton Medical Community Corporation (Benton, TN)																						
Rural Health Services Corp. of Upper East Tennessee (Rogersville, TN)	1	1	2	2	2	1	1	2	3	1	1	2	1	2	2	2	1	1	1	2	2	2
Barrio Comprehensive Family Health Care Center (San Antonio, TX)	1		I I I		2	1		1,2	1	1		1	1	1	1	3	11		I3		3	3
Brownsville Community Health Center (Brownsville, TX)	1	1		3		1 1	1	1	1	1 1	1	1	1	3	1	3	1	1	1	1	1	1
Community Action Council of South Texas (Rio Grande City, TX)	I	1,3	I	I	2	1	1	2	2	1,2	1,2	2	1	1	1	3	1	1	I	1	1	3
Cross Timbers Health Clinics (De Leon, TX)	1	1	2	1	2	1	1	2	3	1	2	2	1	1	1	3	1,2	2	2	1	2	3
Hidalgo County Health Care Corporation (Pharr, TX)																						
Laredo-Webb County Migrant/UHI Program (Laredo, TX)																						
South Plains Health Provider Organization (Plainview, TX)	1	1	1	1	1	1	2	1	1	1,2	1	2	1	1	1	2	1	1	1	1	1	1,2
South Plains Rural Health Services (Levelland, TX)	1	1	2	1	3	1	2	1	3	1	1	2	1	3	3	3	3	3	3	1	1	3
South Texas Rural Health Services (Cotulla, TX)	1	1	1	1	1	1	1	1	1	1	1	1	1	3	1		1	1	1	1		
Su Clinica Familiar (Harlingen, TX)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	3	1	1	1	1	1	1
United Medical Centers (Eagle Pass, TX)	1	1,3	1	1	2,3	1	3	3	3	1	1	1	1	1	1	31	1	1	3	1	1	3
Uvalde County Clinic (Uvalde, TX)	1	1 1		3	3		1 3		1	1 1	1	1	1	3	3	3	12		3	13		1,3
Vida y Salud -Health Systems, Inc. (Crystal City, TX)	1	1	3	1	2	1	1	1	1	I	1	1	1	1	1	3	1	1	1	1	3	3
Salt Lake Community Health Centers (Salt Lake City, UT)	1, 2, 3	1, 2, 3	1, 2, 3	3	3	1	1, 3	3	3	2, 3	1, 2, 3	2, 3	1	1, 3	1	3	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	3	3

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Migrant Health Center	Primary Prevention	Episodic/Chronic Medical	Family Planning	OB - Prenatal	OB - Delivery	Outreach	Transportation	Emergency/After Hours	Hospitalization	Pharmacy	Lab	X-Ray	Health Education	WIC	Nutrition Education/Counseling	Emergency Food	Preventive Dental	Diagnostic/Restorative Dental	Emergency Dental	HIV Screening/Counselling	HIV Counseling/Outreach	HIV Treatment
Stony Creek Community Health Center (Stony Creek, VA)	1	1	1	1	3	1	2	3	3	2	1	1	1	3	3	3	2	2	2	1	1	3
Columbia Valley Community Health Services (Wenatchee, WA)	1	1	1	1	1	1	1	1	1	2	1	2	1	1	1	1	1	1	1	1	1	1
La Clinica Migrant Health Center (Pasco, WA)																						
Okanogan Farmworkers Clinic (Okanogan, WA)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	2	2	2	1	1	1
Sea Mar Community Health Center (Seattle, WA)																						
Yakima Valley Farmworkers Clinic (Toppenish, WA)	1	1	1	1, 2, 3	1, 2, 3	1	1	1	1	1	1	1, 3	1	1	1	1	1	1	1	1	1, 3	1, 3
Shenandoah Community Health Center (Martinsburg, WV)	1	1	1	1	2	1	1	1, 2	1	2	1	3	1	1	1	3	1	2, 2	2, 3	1	1	1
Family Health/La Clinica (Wild Rose, WI)	1	1, 2, 3	1	1	2, 3	1	1, 3	2	3	1	1, 2	2	1	1	1	1, 3	1	1	1, 3	3	3	3
Northwest Community Action Programs of Wyoming (Worland, WY)	1, 2	2	1	2	2	1	1	1	2	2	1	2	1	3	3	1, 2	2	2	2	3		
Tri-County Development Corporation (Guernsey, WY)	1	2	2	2	2	1	1	2	1	2	2	2	1	2	1	3	1	2	2	2	1	2

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Integration/Coordination Matrix of Category 2 Services

Migrant Health Center	Alcohol Abuse - Outpatient	Alcohol Abuse - Inpatient	Drug Abuse - Outpatient	Drug Abuse - Inpatient	Mental Health - Family Violdnece Services	Mental Health Counselling	Mental Health - Hospitalization	Emergency Housing	Resettlement Housing	Farm Labor Housing	Environmental - Water Quality	Environmental - Field Sanitation	Environmental - Pesticide Exposure Surveillance	Environmental - Interagency Emergency Plan	Eligibility Determination - AFDC	Eligibility Determination - Medicaid	Eligibility Determination - Food Stamps	Eligibility Determination - Presumptive Eligibility	Health Dept. Coordination - EPSDT	Health Dept. Coordination - Prenatal Care	Health Dept. Coordination - Immunization	Health Dept. Coordination - Other Service	Linkage w/ MD Residency Program	Linkage w/ Dental School	Linkage w/ Nursing Program	Linkage w/ NP/PA Program	Other Coordinated Service
Clinica Adelante (El Mirage, AZ)	3	3	3	3	2		13	3	3	3	3	3	3	3	2	2	2	3	1	1	1		2	3	1	1	1
Valley Health Center (Somerton, AZ)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3		13	3	12		1		2	3	3	3	
Stockton, CA) rkers Health Centers	2	2	2	2	2	2	3	3	3	3	3	3	1	3	2	2	2	2	1	1	1		2	3	2	2	1
Buttonwillow Health Center (Buttonwillow, CA)															1	1				1	'1				1	1	
Clinica Sierra Vista (Lamont, CA)	1	3	1	3	11		3	3	3	3					3	3	3	1		1	1		1		1	1	
Clinicas de Salud del Pueblo (Brawley, C	2	3	2	3	3	3	3	3	3	3	3	3	3	2	2	2	2	2	1, 2	1	1		3	3	3	3	
Clinicas del Camino Real (Camarillo, CA)	2	3	3	3	1	1	1, 2	3	3	3	3	1, 2	1	1, 2	1	I	3	1	I	I	I				1,2	1, 2	
El Progreso del Desierto (Coachella, CA)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1, 2	3	3	I	1	I		3	3	3	3	
Madera Family Health Center (Madera, CA)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1, 2	3	3	1	1	1		3	3	3	3	
Merced Family Health Centers (Merced, CA)	2	3	2	3	3	2	3	3	3	3	3	3	3	3	3	1	3	3	1	1	1		1		1	1	
Nipomo Community Medical Center (Nipomo, CA)																											
North County Health Services (San Marcos, CA)	3	3	3	3	3	1	3	3	3	3	3	3	3	3	3	2	3	2	3	2	1		3	3	3	1	
Northern Sacramento Valley Rural Health Project (Oliverhurst, CA)																											
Porterville Family Health Center (Porterville, CA)	1, 2	2	1, 2	2	1, 2	1	2	3	3	3	3	2, 3	1, 3	3	3	1	3	1	1	1	1		3	3	3	3	1
Sequoia Community Health Foundation (Fresno, CA)																							1				

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United Health Centers of San Joaquin Valley (Parlier, CA)																											
Colorado Migrant Health Program (Denver, CO)	3	3	3	3	3	3	3	3	3	3	1		1		2	2	2		2	2	2			1	1		
Plan da Salud del Valle (Fort Lupton, CO)																											
Sunrise Community Health Center (Greeley, CO)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1	1	1	1		2	2	3	3	
Valley-Wide Health Services (Alamosa, CO)																											
Delmarva Rural Ministries (Dover, DE)																											
Collier Health Services (Immokalee, FL)	2	2	2	2	2	2	2	3	3	3	2	2	2	2	2	2	2	1	1	1	1		1		1		
Community Health Centers (Apopka, FL)					3	1	1	3		3			1	1	3	3	3	1	1	1	1	1			1	1	
Community Health of South Dade (Miami, FL)	1	3	1	3	3	1	1	3	3	3	3	3	3	1		2	2	1	1	1	1		1	3	1	1	3
Family Health Centers of Southwest Florida (Fort Myers, FL)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1	2	1	1	1		1		1
Family Medical and Dental Centers (Palatka, FL)																											
Florida Community Health Center (West Palm Beach, FL)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1	2	1		1,2		1,2		
Florida Rural Health Services (Avon Park, FL)	3	3	3	3	3	3	3	3	3	3	3	3	3	1	3	3	3	3	1	1	1		3	3	1	1	
Health Resource Alliance of Pasco (Dade City, FL)	2	2	2	2	2	2	3	3	3	3	3	3	3	3	2	2	2	1	1	1	1		1		1		
HRS Palm Beach County Public Health Unit (West Palm Beach, FL)	2	2	2	2	2	2	3	2	2	3	1	1	1	1	2	2	2	1	1	1	1	1	1	3	3	3	
Manatee County Rural Health Services (Parrish, FL)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1	3	1	1	1	1		2		2	2	
Gadsden Primary Care Center (Quincy, FL)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1	1	1	1					
Ruskin Migrant and Community Health Center (Ruskin, FL)																											

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Georgia Migrant Health Program Atlanta, GA)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1, 2	1, 2	1, 2	1, 2	1, 2	1	1	2	2	2	2	2
Family Health Services Corporation Twin Falls, ID)	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	3	3	2	2	
Valley Family Health Care (Payette, ID)	2	2	2	2	3	3	3	3		3	2	2	2	2	2	2	2	1	1	1	1					1		
Community Health Partnership of Illinois Chicago, IL)	2	3	2	3	2	2	3	1	1	2	2	2	2	3	3	3	2	2	3	2	2		3	2	2	3	
Shawnee Health Service and Development Corporation (Murphysboro, IL)																											
Indiana Health Centers (Indianapolis, IN)	3	3	3	3	3	3	3	3	3	3	2	2	2	2	1	1	1	1	1	1	1	1	1		1	1	
Proteus Employment Opportunities (Des Moines, IA)	3	3	3	3	3	3	3	2	2	2	3	3	3	3	3	3	3	3	3	3	3		3	3	3	3	
Kansas City Wyandotte County Health Dept. (Kansas City, KS)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1	1	1		3	3	3	3	
Kansas Dept. of Health and Environment Topeka, KS)	2	3	2	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	2	2	2	2					
Rural Health Centers of Maine Manchester, ME)																	2						2				
Health Delivery Inc. (Saginaw, MI)	3	3	3	3	3	3	2	3	3	3	3	3	3	3	3	3	3	3	3	2	3		2	3	3	3	
Migrant and Rural Community Health Association (Bangor, MI)	3	3	3	3	3	3	3	3	3	3	1, 2	1, 2	3		3	3	3	1 . 3	1, 3	1, 3	1, 3		2	2	2	2	
Northwest Michigan Health Services Traverse City, MI)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	2	2	2		3	2	2	2	2
Pullman Health Systems (Pullman, MI)	1, 2	3	1, 2	3	2	2	2	3	3	3	1	1, 2	1	2	2	1	2	1	1	1			1	3	1	1	
Sparta Health Center (Sparta, MI)																											
Migrant Health Service (Moorhead, MN)	1, 3	3	1, 3	3	1, 3	1, 3	3	3	3	3	3	3	3	3	3	3	3	3	1, 3	1	1, 3	3	3	1	3	3	1, 3
New Madrid County Group Practice Clinic (New Madrid, MO)																											
Montana Migrant Council (Wings, MT)	1	3	1	3	3	3	3	3	3	3	1	3	3	3	1	1	1	1	1	1, 2	1						1
Nebraska State Dept. of Health (Lincoln, IQ	3	3	3	3	3	3	3	3	3	3	3	3	3	3		2	3	1	3	2	2						

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Bridgeton Area Health Services 3 Bridgeton, NJ)	3	3		3	3	3	3	3	3	3	3	3	3	3	3	3	3	3		12	12	3		2	3	1	
Ia-Lantic Health Services (Hammonton, NJ)	2	3	2	3	2	2	3	3	3	3	3	3	2	3	2	2	2	1	1	1	1	1	1	1	1		
La Clínica de Familia (San Miguel, NM)	2	2	2	2	2	2	1, 2	2	2	2	2	2	2	2	2	2	2	2	1	2	1	1	1	1	1	1	1
Hudson Valley Migrant Health 2 Peekskill, NY)	3	1, 2, 3		3	3	3	3	3	3	3	3	3	3	3	3	1, 3	3	1, 2	2	1	1, 2		3	3	3	1	1, 2
Oak Orchard Community Health Center Brockport, NY)	2	2	2	2	2	2	2	3	3	3	3	3	3	3	2		2		2		1	1		1	111		1
Sodus Health Center (Sodus, NY) 3		3	3	3	3	3	3	3							3	3	3	3	1	1	1						
Blue Ridge Health Center Hendersonville, NC)	13			13	11		2	2	2	2	2	2	2	2	1	1	1	1	1	1	1	1		1	1		1
Goshen Medical Center (Faison, NC)	3	3	3	3	3	3	3	3	3	3	3		13	3	3		3	3		3		2		2	2		1
North Carolina Dept. of Environment, Health, and Natural Resources (Raleigh, NC)																											
Tri-County Community Health Center Newton Grove, NC)																											
Community Health Services (Fremont, OH)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1	1	1	1	1	2	2	3	3	
FHS Medical Center (Greenville, (OH)																											
La Clínica del Cariño Family Health Care Center (Hood River, OR)	3	3	3	3	3	1, 3	1, 3	3	3	3	3	3	3	3	3	3	3		3	1	1	1	1	1, 2	1, 2		
La Clínica del Valle (Phoenix, OR)	3	3	3	3	3	1, 3	3	3	3	3	3	3	3	3	2, 3	2, 3	3		1	1	1, 3	1		1	1	1	1
Salud Medical Center (Woodburn, OR)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1	1			1	1	1	1	1
Virginia Garcia Memorial Health Center (Cornelius, OR)	1	2	1	2	2	2	2	2	3	3	3	3	2	3	3		3		3		311	1		12		11	
Pennsylvania Rural Opportunities (Camp Hill, PA)	3	3	3	3	3	3	3	2	2	2	3	3	3	3					1	1	1	2					
Castañer General Hospital (Castañer, PR)	3	1, 3	1	1, 3	3	3	3	3	3	3	1, 3	1, 3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	
Concilio de Salud Integral de Loiza (Loiza, PR)	1	1		1	1	3	1			3	3	3	2, 3		3		3		3	11		1	1		1	1	1

1 indicates a direct service which is provided by project staff

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Migrant Health Center	Alcohol Abuse - Outpatient	Alcohol Abuse - Inpatient	Drug Abuse - Outpatient	Drug Abuse - Inpatient	Mental Health - Family Violdnece Services	Mental Health Counselling	Mental Health - Hospitalization	Emergency Housing	Resettlement Housing	Farm Labor Housing	Environmental - Water Quality	Environmental - Field Sanitation	Environmental - Pesticide Exposure Surveillance	Environmental - Interagency Emergency Plan	Eligibility Determination - AFDC	Eligibility Determination - Medicaid	Eligibility Determination - Food Stamps	Eligibility Determination - Presumptive Eligibility	Health Dept. Coordination - EPSDT	Health Dept. Coordination - Prenatal Care	Health Dept. Coordination - Immunization	Health Dept. Coordination - Other Service	Linkage w/ MD Residency Program	Linkage w/ Dental School	Linkage w/ Nursing Program	Linkage w/ NP/PA Program	Other Coordinated Service
Corporación de Servicios de Salud ntegrales de la Montaña (Naranjito, PR)	1	2	1	2	2	1	2	3	3	3	3	1	3	2		1	2	1	2	1	1		3	3	3	3	
Corporación de Servicios de Salud a Migrantes Agrícola (Cidra, PR)	1	3	1	3	2	2	2	3	3	3	1	3	1	2		2	2	2		2	2	2	2	1	2		
Diagnostic and Treatment Center of La Playa de Ponce (Playa de Ponce, PR)																											
Migrant Health Program Western Region Mayaguez, PR)	2	2	2	2	3	1	3	3	3	3	3	3	3	3	3	3	3	3	3	1	1		2	1	2	2	
Primary Health Services Center Patillas Patillas, PR)	1	2	1	2	1, 2	1, 2	2				1	1	1	1	2	1	2	2	1	1	1		1		1		
Franklin C. Fetter Family Health Center Charleston, SC)																											
MEGALS Rural Health Association [Trenton, SC)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1	1	1	1, 2	2	3	2	3	1
Office of Rural Health, Migrant Health, and Primary Care (Columbia, SC)																											
Benton Medical Community Corporation (Benton, TN)																											
Rural Health Services Corp. of Upper East Tennessee (Rogersville, TN)	3	3	3	3	3	3	3	3	3	3					2	2	2	2	2	2	2						
Barrio Comprehensive Family Health Care Center (San Antonio, TX)															1	1	1	1	1	1	1			1			
Brownsville Community Health Center (Brownsville, TX)	3	3	3	3	3	1	1	3	3	3	3	3	3	3	1	1	1	1	1	1	1		1	1	1	1	
Community Action Council of South Texas (Rio Grands City, TX)	3	3	3	3	3	3	3	3	3	3	1	1	1, 3	3	1	1	1		1	1, 2	3		3	3	3	3	
Cross Timbers Health Clink4 (De Leon, TX)	2	3	2	3	2	2	3	3	3	3	1	3	1	3	1	1	2	2	1	1	1		3	3	1	1	
Hidalgo County Health Care Corporation (Pharr, TX)																											
Laredo-Webb County Migrant/UHI Program (Laredo, TX)																											

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South Plains Health Provider Organization (Plainview, TX)	1, 2	2	1, 2	2	2	1, 2	2	3	3	3	3	3	3	2, 3	2	1, 2	2	1	1	1	1		1		1	1	1
South P&ins Rural Health Services (Levelland, TX)	3	3	3	3	3	3	3	3	3	3	3	3	1, 3	3	3	3	3	1	1	1	3					1	
South Texas Rural Health Services (Cotulla, TX)	1		1															1	1								2
Su Clinica Familiar (Harlingen, TX)	1	3	1	3	1	1	3	3	3	3	3	3	3	3	1	1	3	1	1	1	1		1	1	1	1	
United Medical Centers (Eagle Pass, TX)	1	3	1	3	3	3	3	3	3	3	3	3	3	3	3	1	3	1	1	1	1						
Uvalde County Clink (Uvalde, TX)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3			1	1	
Vida y Salud - Health Systems, Inc. (Crystal City, TX)	3	3	3	3	3	3	3	3	3	3	3	3	1	2	3	3	3	1	1	1	1		2	3	2	2	
Salt Lake Community Health Centers (Salt Lake City, UT)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	1, 3	1, 2, 3	2, 3	1, 2, 3	1, 2, 3				1	
Stony Creek Community Health Center (Stony Creek, VA)	1	3	1	3	2	1	3	3	3	3	3	3	3	3	3	3	3	3	1	1	1	1	1	3	3	3	
Columbia Valley Community Health Services (Wenatchee, WA)	2	2	2	2	3	3	3	3	3	3	3	3	3	3	2	2	2	2	3	3	3	3					
la Clinica Migrant Health Center (Pasco, WA)																											
Okanogan Farmworkers Clinic (Okanogan, WA)	2	3	2	3	2	1, 2	2	3	3	3	3	3	1	3	1	1	3	1	1	1	1	1	1	3	3	1	
Sea Mar Community Health Center (Seattle, WA)																											
Yakima Valley Farmworkers Clinic (Toppenish, WA)	3	3	3	3	1, 2, 3	1, 2, 3	1, 2	2	2	2	3	3	2, 3	3	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3	2	2	2		1	1	1	1	
Shenandoah Community Health Center (Martinsburg, WV)	3	3	3	3	3	3	3	3	3	3					3	3	3	3	3		1, 3	1, 3			1	1	1
Family Health/La Clinica (Wild Rose, WI)	3	3	3	3	3	1, 3	3	3	3	3	3	3	3	1, 3	3	3	3	1, 3	1	1, 3	1, 3				2	3	1
Northwest Community Action Programs of Wyoming (Worland, WY)	3	3	3	3	3	3		1							3	3	3		3	3	3						
Tri-County Development Corporation (Guernsey, WY)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	2	2	2	2	2	2	1		3	3	3	3	

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Appendix 4

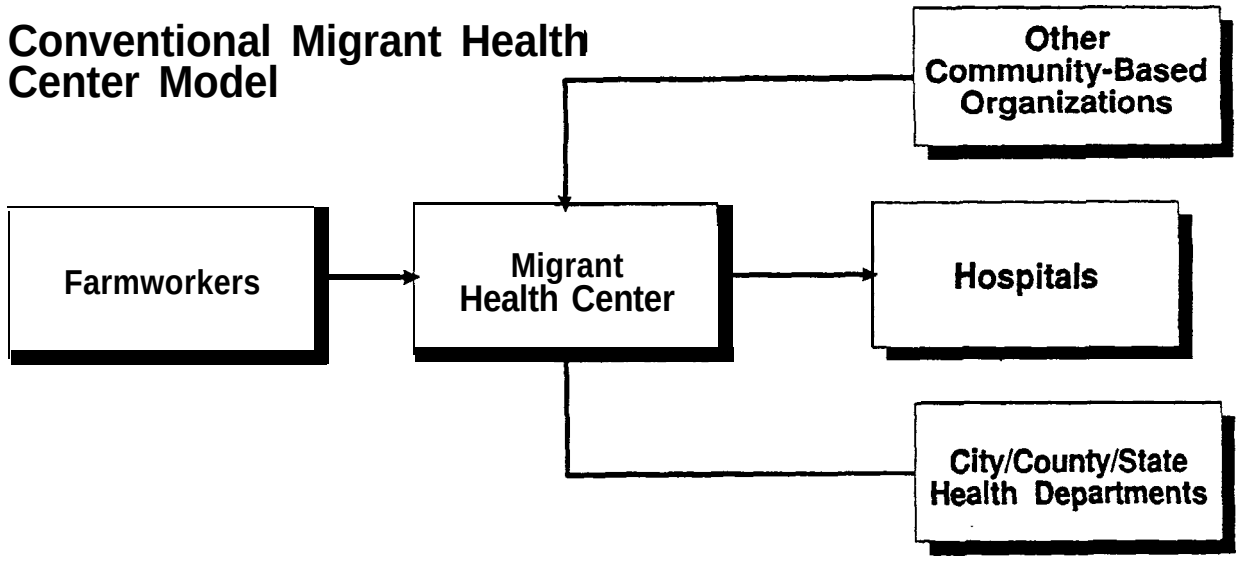
Comparison of Conventional and Coordinated/Integrated Health Care Delivery Models

and

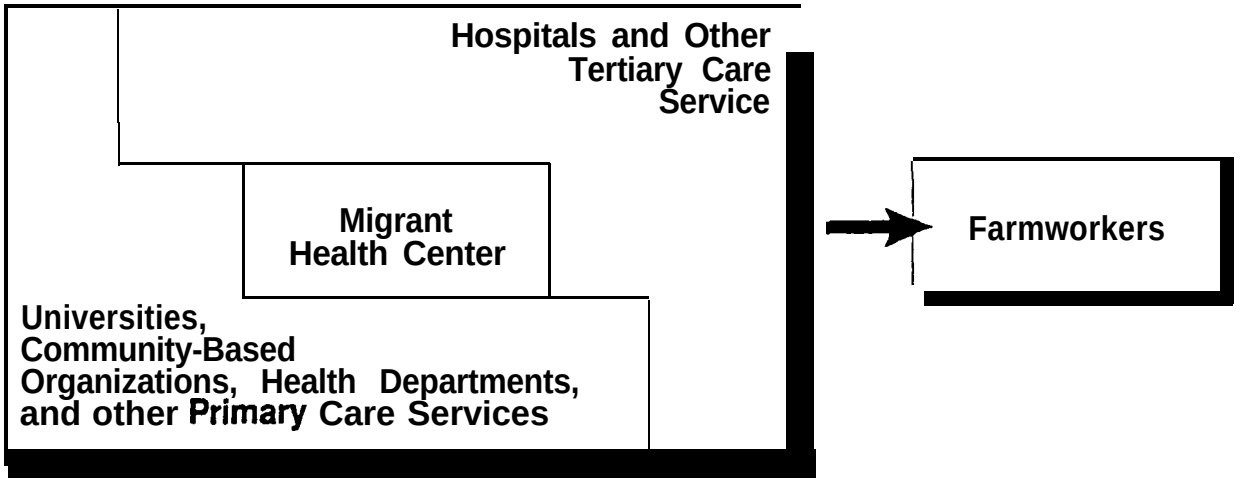
Integrated Migrant Health Center Service Delivery Model

Comparison of Conventional and Coordinated/Integrated Health Care Delivery Models

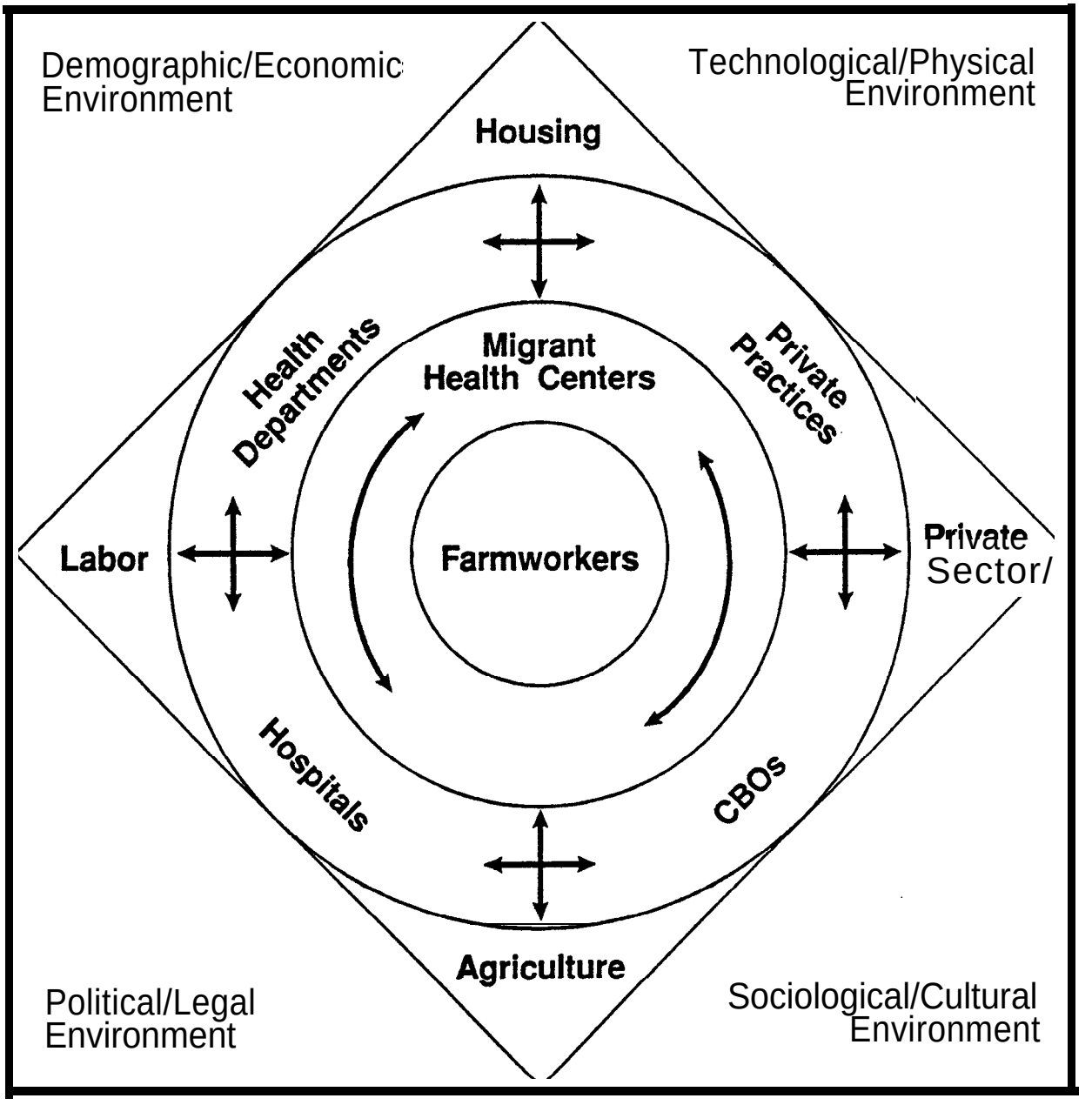
Conventional Migrant Health Center Model



Coordinated Migrant Health Center Service Delivery Model



Integrated Migrant Health Center Service Delivery Model



Appendix 5

Project Work Plan

Integration and Coordination of Services at Migrant Health Centers

Project Workplan

Submitted by:

National Migrant Resource Program, Inc.
2512 South IH35, Suite 220
Austin, TX 78704
(512) 447-0770

February 20, 1991

Contents

Project Overview iii

Workplan Narrative 1

Task 1—Initial Meeting 1

Task 2-Background Literature Review 1

Task 3—Prepare Detailed Workplan 2

Task 4—Prepare a Matrix of Services/Programs by MHC 2

Task 5—Develop List of Candidate MHCs for Case Studies 3

Task 6—Develop Final Site Visit Protocols 4

Previsit Activities 4
On-Site Activities. 6
Overview of Cost Analysis. 6
Cost Data Requirements 6
Data Sources 8
Data Collection Approaches 8
Data Analysis Approach 9
Post-Site Visit Activities 11

Task 7—Conduct Test of Protocols and Instruments 12

Task 8—Provide Oral Briefing on Site Protocol Test 12

Task 9—Refine Site Visit Protocols 12

Task 1O-ConductBemainingSiteVisit.s 12

Task 11—Prepare Draft Monograph, Final Report, and Executive Summary 13

Task 12—Meet With GPO to Discuss Draft Reports 14

Task 13—Deliver Final Briefmg 14

Task 14—Deliver Final Reports 15

Exhibits 17

1. Candidate Services for Integration or Coordination 17
2. Key Indicators of Comprehensive Success 19
3. Pre-Site Visit Protocol 21
4. Site Visit Protocol 23
5. Post-Site Visit Protocol 25
6. Preliminary Interview Guide: MHC Executive Director 27
7. Preliminary Interview Guide: MHC Clinical Director 29
8. Preliminary Interview Guide: MHC Chief Financial Officer 31
9. Preliminary Interview Guide: Participating Agency/organization Representative . . . 33
10. Preliminary Interview Guide: Manager of Coordinated/Integrated Service, ... 35
11. Collaborative Work and Service Agreements Component Checklist. 37
12. Data Collection Instrument: Resource Use Data 39
13. Data Collection Instrument: Unit Cost Date 41

Integration and Coordination of Services at Migrant Health Centers

Project Overview

Background

The National Migrant Resource Program has been awarded funding from the U.S. Department of Health and Human Services, Health Resources and Services Administration, to identify the extent of integration and coordination of services among migrant health centers and other organizations at the federal, state, and local levels. Coordination of services is critical to the delivery of comprehensive care to any population, but it is even more crucial when delivering services to migrant and seasonal farmworkers. The mobility of the population, its relative disenfranchisement from traditional services, and the cycle- of poverty make farmworkers one of the hardest-to-reach underserved populations. Language barriers, geographic isolation, and cultural and racial differences further alienate farmworkers from programs for the indigent. Moreover, migrant farmworkers generally work or reside in areas with a shortage of health and social service resources for the year-round population, where existing systems cannot respond to the seasonal influx of a high need population.

Section 329 of the Public Health Service Act provides support to make health services available in a manner which is both accessible and appropriate to farmworker needs. Other migrant-specific services include programs funded through the Department of Labor, Department of Education, Department of Health and Human Services, Legal Services Organization, Farmers Home Administration, and the WIC program administered through the Department of Agriculture. Further, the Department of Labor is

responsible for occupational health and safety, the Environmental Protection Agency regulates the use of pesticides, and the Department of Transportation is involved in regulation of transportation programs affecting the movement of both crops and workers,

The intent of Congress was to recognize that a seasonal influx of farmworkers could easily overburden a rural community's human services system. It was never intended that migrant-specific services should totally segregate farmworkers from other kinds of community services. Therefore, integration of migrant health programs becomes crucial, not only with other federal programs, but also with state and local programs that serve the poor, including farmworkers. Only in this way can farmworkers be assured access to the existing mainstream service delivery system.

The recent long-range strategic work plan of the federal Migrant Health Program introduces a fresh focus upon the development of Interagency Coordinating Councils at the state and local levels. However, until coordination is recognized officially as a critical issue and incorporated into the monitoring and funding standards of the Migrant Health Program, such coordination will not occur in all migrant health centers. Currently, individual programs make it happen by virtue of personal and corporate commitment.

The purpose of this study is to evaluate in detail the factors and circumstances which come into play to create an 'exemplary" model of interagency coordination of services. Further, the study will identify the extent of integration and coordination at this time, and provide measures which may serve as a baseline against which to compare future status and derive quantitative descriptions of change. Documentation will include site visits and studies of nine migrant health centers. In the process of selecting the sites to be studied, the experiences of all 329-funded health centers will be crudely measured, thus establishing a program-wide baseline and providing a database for program-specific analyses. In addition, the project will develop a methodology for estimating cost savings attributable to integration and coordination.

Approach

Working with the Center for Health Policy Studies, NMRP will use existing information and data collection processes to avoid duplication, enhance efficiency, and minimize the burden on health center and PHS Regional Office staff. Because each case study site will be different, the interview guides, protocols, and other instruments will be tailored to the health center and the specific programs which characterize that center's activities. However, a set of generic interview guides and data collection plans will be developed before site visits begin.

An initial matrix of services and/or programs which are candidates for integration and coordination will be developed from previous NMRP surveys used to prepare the annual *Migrant Health Centers Referral Directory. This* will provide PHS Regional Program Consultants with reasonably detailed data for each migrant health center in

their region. RPCs will be asked to verify the information, provide additions as necessary, and nominate candidates for the case studies.

Neither the Regional Offices nor the Migrant Health Program Central Office has information for all migrant health centers regarding the full array of sub-programs which could be part of health center activities. Information as to whether the coordinated programs are used at a token level or by a majority of center users is also absent. Therefore, additional information is needed for the program-wide assessment of integration and coordination. For its 1991 directory, NMRP will use an expanded survey instrument to provide information on a broader range of programs offered on site or through referral, and will include a quantitative dimension to indicate the degree to which the offered services are used by the health center's patients. The results of the 1991 survey will be used in the analysis and final report for this study. The final report will be completed in October 1991.

For more information on this study contact Karen Mountain, Director of Clinical Resources, National Migrant Resource Program, 2512 South IH35, Suite 220, Austin, TX 78704, (512) 447-0770.

integration and Coordination of Services at Migrant Health Centers

Workplan Narrative

The contractual scope of work calls for the preparation of a detailed workplan five weeks after contract initiation. The present document represents that workplan, building upon and expanding the concepts contained in the original proposal, including schedules, draft criteria, site visit protocols and other documents. The detailed workplan incorporates the suggestions and comments from the review of the preliminary plan contained in our proposal (reviewed during initial meeting with GPO on October 24, 1990), and includes further development of site visit protocols and draft instruments as well as a plan for estimating cost savings attributable to integration and coordination.

The workplan contains brief summaries of activities planned in each task area. Individuals responsible and the schedule for achievement of milestones are given within the section on each task. Tasks already completed, such as the Project Initiation Meeting, are not described. However, the task numbers used in this workplan are those used in our original proposal in order to facilitate cross-reference.

Task l-Initial Meeting

This task was completed October 24, 1990.

Task 2—Background Literature Review

The initial literature review focused on recent literature, and was completed within a month of contract initiation. Our review began with searches for relevant information through the following sources:

- NMRP's Resource Center
- The National Library of Medicine MEDLARS and MEDLINE system (both NMRP and CHPS utilize Grateful Med for on-line searches)
- OASPE's Policy Information Center
- Literature collected in 1985-86 during the study of WIC/MCH coordination

We also included a number of documents specific to the Migrant Health Program, such as the Office of Migrant Health Strategic Workplan, the MCN document on migrant and seasonal farmworker health objectives for the year 2000, and the PHS objectives for the year 2000.

The products of this task will consist of several items, the first of which will be an annotated bibliography of materials on coordination and integration of health and supportive services published *or* produced within the past five years. At this time the preliminary bibliography is complete; however, literature searches of business, management and other relevant data sources outside the traditional arena of health-related information will be conducted on an ongoing basis throughout the contract period. A truly comprehensive bibliography will be submitted as part of the final report. That literature appearing in the bibliography which is judged to be relevant to the present study and which is not already located in the NMRP Resource Center will be acquired, cataloged according to established procedures, and made available to the study team members and GPO for future use. We continue to pursue some of the documents cited in the preliminary bibliography, although most are now in-house. We will identify and review documents which appear to be useful for the current study. For each document which is found to be useful to the study, we will prepare an abstract for use in the final comprehensive annotated bibliography. The preliminary annotated bibliography was delivered to the GPO on December 1, 1990.

Although all members of the study team have contributed to the collection of literature, the preparation of the comprehensive and annotated bibliography is being performed by the NMRP Resource Center under the direction of Ms. Del Garcia.

Task 3-Prepare Detailed Workplan

The present report represents the product of this task.

Task 4-Prepare a Matrix of Services/Programs by MHC

We will use information collected to prepare the 1990 *Migmnt Health Centers Referral Directory,* the only centrally available information on the services offered by each migrant health center. The original questionnaires completed by each migrant health center which were used to compile the directory are being used to prepare a matrix of services, indicating whether the service is provided through referral or direct delivery for each health center. We proposed to use these existing data on migrant health center services (previously collected by NMRP) complete the matrix on a timely basis, and to use these data for the development of preliminary site selection recommendations. To facilitate a more comprehensive analysis of the extent of integration and coordination among migrant health centers for use in the final report, NMRP will expand its regular annual survey to be sent out in January 1991. Tabulations from that expanded survey will be available by June 1991 for analysis.

The first matrix of migrant health centers is being prepared on a region-by-region basis, and includes an analysis of potential coordination between migrant health centers and other service organizations. This matrix is based upon the basic service delivery information found in the *Migrant Health Centers Referral Directory* published by NMRP in the spring of 1990. This information was updated through a national survey in January of 1990. Using these data already available in the NMRP data base, the matrix will be completed as fully as possible and then sent to the Regional Program Consultants for review, completion, and annotation of any special features that should be taken into consideration. The matrix will represent some but not all of the services listed in Exhibit 1. We do not believe that there is a central source of, or that regional office staff can reliably supply, information on some of the minor support services listed in Exhibit 1 as candidates for the integration/coordination, but which are not covered in the NMRP directory inventory. We do have information on several services not published in the directory, and will obtain this information from the original survey forms for use in the matrix.

We propose to request that regional offices check, enrich and return the matrices within three weeks after receipt. We will call those regional offices which are late in responding. We also will ask the Regional Program Consultants for migrant health to provide recommendations of migrant health centers in their region which have exemplary integrated or coordinated services. (All recommended grantees should also be in compliance with Section 329 funding guidelines.)

A second and more detailed matrix will be prepared in conjunction with the data gathering phase for the 1991 *Migrant Health Centers Referral Directory*. NMRP proposes to expand the database currently established for the production of the annual directory to include information on the extent of coordination and integration of services. To accomplish this, NMRP would ask a series of questions directly of the centers in order to ascertain the extent and degree of cooperation with other service organizations. The form would include all of the categories of services indicated in Exhibit 1, and would also provide a "score" within each cell to represent the degree to which this is a meaningful service to the users of the migrant health center. This survey information would be collected on site, and would identify key contact persons **and** specific services provided both on site and by referral.

In that this process is already in place, there is a certain economy of scale to be achieved. Specific additional activities (and costs) attributable to this project will include the design of the expanded survey tool, additional data collection reminders, data clean up, data entry, and analysis time. Results of the survey analysis will be included in the final report of this project as a matrix of services available through coordination efforts at each migrant health center. This matrix will be completed in addition to the other matrices produced in Tasks 4 and 5 for the purpose of selection of the study candidates. This proposed matrix will exceed the requirements of the original RFP, but will provide a much greater ability to evaluate the extent on integration and coordination throughout the migrant health program than would otherwise be possible.

Task 5—Develop List of Candidate MHCs for Case Studies

Once the matrix has been compiled, it will be circulated to the Primary Care Division directors in the regional offices for enhancement, weighting, and recommendations as to candidate projects for case study. Copies will be sent concurrently to the Migrant Health Regional Rogram Consultants. Recommendations from these PHS staff, together with our application of selection criteria to the universe of migrant health centers, will then be used to compile a pool of 15 to 20 candidate health centers, from which 9 exemplary models will be selected. The following selection criteria will be used to reduce the number of candidates to 15 or 20:

- The MHCs selected should have *formal arrangements for the integration* of a supportive service, or coordination with another organization which provides a supportive service. Such arrangements should have been in place for at least 12 months and must *involve at least two services.*

- *Recommendation of the cognizant regional office* based on both the success of the integration and coordination of activities and general compliance with Section 329 funding guidelines.

- *Geographic representation.* A fiied percent by migratory stream or upstream vs. downstream cannot be specified. Instead, we propose to use 'minimum threshold" criteria. Thus, no fewer than one third of the candidates should be upstream migrant health centers; at least one third should be downstream migrant health centers. The actual proportion could vary from one third to two thirds. Similarly, at least one fourth of the candidates should come from each of the eastern, midwestern, and western migratory streams, but no more than three of the 15-20 candidates should come from any one PHS region.

- *Funding types represented* At least 20 percent will be migrant health centers (Section 329 funded only); at least 50 percent will be conjoint-funded (Section 329/330) health centers. Although close to 80 percent of migrant health centers are conjointly funded, the actual percent of conjoint projects among the case study candidates could range from 50 to 80 percent (10-16 of 20 recommended candidates).

- *Service delivery models represented. The* pool of candidates must contain at least one voucher program candidate, two nursing program model candidates (a combination nursing/voucher model can count as one half of a project in each type), and at least three health center model candidates. Note that multi-site health centers will only be considered to be one candidate for site selection even though separate service sites within the center may represent different models and types for which representation is sought.

- *Diversity among the participating agencies, services OF programs* which are integrated into or coordinated with the migrant health center's primary care services. We feel that it is critical to not only examine a number of types of services, but also to be sure to include several examples among the case studies

of integration of services or coordination with local and state health departments.

For each candidate included in the pool of 15-20 candidates, a description and justification for inclusion will be prepared. The format for the description and justification will consist of tables which display the array of characteristics used as selection criteria (e.g., list of candidates by state, upstream vs. downstream, and PHS region). All information will be validated through the use of phone contacts with the regional program consultant, the migrant health centers, and *other* appropriate points of contact. Key indicators of success will begin to be identified (Exhibit 2).

Task 6—Develop Final Site Visit Protocols

Our site visit protocols are divided into three components:

- *Previsit Activities.* This includes telephone contacts with the regional office, primary care association, and health center staff, compilation of background materials, contacts with the health center to arrange the visit, scheduling of appointments for on-site interviews, and preparation of forms for recording information (Exhibit 3).
- *On-site Activities. This* includes the general schedule for briefing of key health center staff on the study protocol, collection of cost data, conduct of interviews, observations, visits to other participating agencies in the integrated or coordinated services, review of evaluation materials, and the exit meeting with the health center director (Exhibit 4).
- *Post-visit Activities.* This includes writing of the case study reports, follow-up on missing information or discrepancies among records, circulation of the draft report back to the health center for review and comment, preparation of "thank you" letters, and finalization of the site report (Exhibit 5).

Previsit Activities

Previsit activities begin once the final selection of sites has been made. The first step will be to compile a background folder on each site for previsit review by the site team and as a resource for subsequent preparation of the case study report. Background materials requested will include:

Materials Requested	Source
BCRR Summary Sheet	**BHCDA**
Excerpts from Atlas of State Profiles for site area	Research Coordinator
Copies of relevant interagency agreements	Site
Most recent grant application	Site
Organizational chart	Site
Annual report	Site
6 months of minutes from Migrant Coordinating Council	Site
Detailed COPC plan, if not in grant	Site
Long Range Plan	Site
Last 12 months Board minutes	Site
Cost study data:	Site
	Most recent audit report
	Chart of accounts
	Volume/utilization summaries for services studied
Any analyses/evaluations of integrated activity (QA, etc.)	Site

Also included will be excerpts from telephone discussions with regional office and primary care association staff concerning the site and its success with coordination and/or integration of services, as well as the tentative on-site schedule for interviews and observations, to include time and location for each person to be interviewed or office to be visited to collect data.

The migrant health center will be asked to designate a person to make appointments and to serve as facilitator for the site visit. Timing of the site visit will be coordinated with this individual. The week prior to the visit, the site visit team leader will contact the designee to confii all arrangements, including who will be invited to the kick-off briefing and exit de-briefing.

Generic interview guides have been developed for each migrant health center 'staff person to be interviewed, and for use when interviewing staff at participating agencies. These guides are necessarily general at this time, but provide space for the site visit team to insert activity-specific questions for follow-up on site. Exhibits 6, 7, 8, 9, and 10 provide draft interview guides for the Executive Director, Clinical Director, Chief Financial Officer, Participating Agency Representative, and manager of the coordinated service, respectively. Note that the actual array of individuals to be interviewed by job title may require tailoring of an interview document which includes portions of the questions appearing on several of these generic guides. The interview guides will be used to foster discussion, and do not represent a limiting set of questions to be asked. By reviewing the guides after reading the background materials on each site, the site visit team will be able to fine-tune the guides to bring out those issues for which more detail is needed and to prompt interviewees to offer documentation if available. In addition, the site vitis team will review the elements of each collaborative agreement (Exhibit 11).

In the week prior to the visit, the team members will review the available materials and attempt to complete each interview guide. This effort will indicate which questions

are not relevant, which can already be answered, and which warrant special attention during the visit. We expect that our site visit teams will know much about the migrant health center and its coordinated services before they arrive on site, and will be able to devote their time to following up on aspects not well documented in the background materials rather than spending time on superficial descriptions.

On-Site Activities

The on-site protocol calls for a two-to-three-person site visit team to spend two days in the field interviewing health center staff, collecting cost data, interviewing representatives of participating agencies, and reviewing service logs or other sources of

Table 1. Cost Data Requirement and Data Sources

Research Question	Data Requirement	Data Sources					
		Other Study Components	Interviews and Observations		Agency Financial Records		
			MHC	Other Agencies	Payroll	BCRR	Other
1. For services of interest (i.e., those that are integrated), what are direct and indirect costs of the services (including donated services as they are provided in an integrated services framework by MHG and other agencies)?	›Services to be investigated ›Direct resources-existing service delivery approach-staff, supplies, other ›Indirect resources-existing service delivery approach-facilities and administrative costs ›Unit cost of resources	✓	✓ ✓	✓ ✓	✓	✓	✓
2. For services of interest, what are the direct and indirect costs that would be incurred by MHG and other agencies if the services were not integrated?	›Direct resources-non- integrated service delivery approach ›Indirect resources-non- integrated service delivery ›Unit cost of resources (additional as required)		✓ ✓	✓ ✓	/	✓	✓

evaluative data. The duration of the site visits and the list of organizations and contacts to be interviewed will also be influenced by the final decision on selection criteria and actual sites, and may vary from site to site. We expect that the average site visit will be approximately four person-days spread over a two-day period. The first site visit will serve as the test site and will include all site visit team members.

The on-site visits will begin with a briefing of health center management staff (at a minimum the Executive Director). Based on the services coordinated and/or integrated, we will interview selected members of the health center staff, although the core set of positions for interviews will be those listed (see Exhibits 6 through 10) or their designees. We will depend heavily on the migrant health centers to help us identify information we seek to gather. We need to obtain information on how the integrated/coordinated service works, the specific arrangements, how and why they developed, early barriers and how they were overcome, the degree of utilization, costs of operating the service, what it would have cost without the arrangement, how it can be improved, mistakes to avoid, and critical elements or short cuts to include in recommendations to other migrant health centers. We will also use the health center's organizational chart to help identify who in the health center can provide this information.

Overview *of Cost Analysis*

The cost analysis which will support the study of integration and coordination of services at migrant health centers must provide answers to four questions:

- For services of interest (i.e., those that are provided through integration), what are the direct and indirect costs of the services (including donated services as they are provided in an integrated services framework by migrant health centers and other agencies?
- For services of interest, what are the direct and indirect costs that would incurred by migrant health centers and other agencies if the services were not integrated?
- What are the marginal costs of each service of interest when services are provided in an integrated framework?
- What are the financial savings (defined as added financial support less marginal cost) accrued by migrant health centers when services are provided in an integrated framework? If health centers do not accrue savings, do savings accrue to other agencies for the services investigated?

The data requirements and the data collection approach for gathering data to address these questions are discussed below.

Cost Data Requirements

Migrant health centers do not maintain their cost data in a format that easily provides data on the costs of specific services. Instead, health centers use accounting systems

that accumulate aggregate costs of resources they use across all services (e.g., total salaries, total supplies). In order to answer the questions which have been identified, therefore, it is necessary to convert these aggregate data to service-specific costs. The approach used to accomplish this conversion is known as resource costing.

In resource costing, interviews and observations are conducted to identify the resources used for each service provided. Once resources are identified, prices for each resource are gathered from accounting records. For example, an interview and observation process will identify the staff time devoted to a service while the costs for staff time will be gathered from payroll records (salaries) and the agency's general ledger or BCRR reports (fringe benefits as a percentage of salaries). Resource costing has been widely used by the Center for Health Policy Studies to identify the costs of specific services in community health centers and other out-patient settings.

The data requirements related to each research question are identified in Table 1. In addition, the sources of data to be used for accumulating each requirement are also identified.

Data *Sources*

As shown in Table 1, three sets of data sources will be used for the cost analysis. A typology of services affected by MHC integration and coordination activities will need to be developed to facilitate response to the first research question. This typology will be prepared independently prior to initiation of the cost analysis.

Table 2. Service A-N
Costs of Services Provided in an integrated Framework

Cost Element	Migrant Health Center								
	1	2	3	4	5	6	7	8	9
Direct costs: Personnel costs Fringe benefits Materials and supplies Other direct costs									
Total Direct Costs									
Indirect costs: Space Equipment Overhead/administration Other indirect costs									
Total Indirect Costs									

Table 3. Service A-N
Costs of Services If Provided in a Non-Integrated Framework

Cost Element	Migrant Health Center								
	1	2	3	4	5	6	7	8	9
Direct costs: Personnel costs Fringe benefits Materials and supplies Other direct costs									
Total Direct Costs									
Indirect costs: Space Equipment Overhead/administration Other indirect costs									
Total Indirect Costs									

Table 4. Service A-N*
Marginal Costs of Services
MHC 1-9*

Cost Element	Direct Costs in In-Patient Service Delivery	Direct Costs for Non-Integrated Service Delivery	Marginal Cost
Personnel costs Fringe benefits Materials and supplies Other direct costs			
Total			

Table 5. Financial Savings Due To
Service Integration
MHC 1-9*

Services	Added Financial Support	Marginal Cost	Financial Savings
A			
B			
C			
D			
E			

As noted, interviews and observations will be used to identify the resources used for the services included in the typology. These interviews will be specific to the services conducted (i.e., interviews will be held with the person in each migrant health canter or agency that provides an integrated service who is closest to the service provision process). The interviewee will be asked to identify each resource input by type and amount used to provide the service in both the existing integrated service delivery approach and in a hypothetical service delivery approach which is not integrated. In this context, data requirements for questions 1 and 2 will be combined.

Also as noted, unit cost data to be applied to resource data will be collected from migrant health center and other agency financial records. Hourly rates for staff will be collected horn payroll records, and costs of materials and supplies will be collected from the most recent supplier invoices available, Other data will be gathered from BCRR reports for migrant health centers and from other agencies' general ledgers. If unit cost data for a specific resource cannot be gathered from accounting records, financial and other management personnel will be asked to estimate unit costs as necessary.

In order to calculate savings, revenues received by migrant health centers to support the provision of additional service components in an integrated service setting will need to be gathered. These revenues will be identified in interviews with health center and other agency staff, and will be validated by reviewing the agency general ledger and/or cash receipts records.

It should be understood that the inventory of resources identified for questions 1 and 2 will include resources for which there are no cash expenditures, such as volunteer time. These resources will also be identified and priced. Observations will be used to validate data collected during interviews. Each integrated service will be observed in each setting to confirm the accuracy of resources identified in interviews. Observations will be used for validation purposes only, and not for original data collection.

Data Collection Approaches

Exhibits 12 and 13 are draft data collection instruments to be used to collect resource and unit cost data. Because services investigated may differ substantially among the nine migrant health centers to be studied, instruments need to be flexible. A primary concern of the cost data collection is to obtain accurate data without imposing an undue burden on the staff of the health center or other participating organization. In order to facilitate this process, we will contact the individual in charge of financial data and reporting at the migrant health center by telephone well in advance of the scheduled site visit. The purpose of the cost data collection will be explained, and we will emphasize our intention to make use of readily available data and reasonable estimates. During the telephone conversation, we will also attempt to gain an understanding of the health center's accounting system and the manner in which resources used or obtained for coordinated services are recorded. This will permit appropriate tailoring of the data collection instruments and on-site protocols. The financial officer contacted at the migrant health center will also be asked to identify his or her

counterpart(s) in participating agencies to be included in the case study. Similar telephone calls will be placed to those individuals in order to explain the cost data collection for integrated services.

The cost data collection forms and instructions will be sent to the migrant health center financial officer to review prior to the site visit. This information will include illustrative examples, and will request the health center to provide us with specific documentation. If this information is provided prior to the site vitis, it will reduce the data collection time on site and enable the site visit team to focus on areas that require further information or clarification. If time does not permit receiving the documentation in advance, data collection will still be more efficient if the site has our request and can have the material ready at the time of the site visit. The following documentation will be requested:

- Chart of accounts
- Most recent audit report or annual financial report
- Personnel classification and salary schedule

The emphasis of the on-site data collection will be on understanding what services are integrated and how they are defined and quantified in terms of resources consumed or obtained. The actual computations will be completed off-site as part of the data analysis.

Data Analysis Approach

Data analysis will be completed to address each question identified in Section 1. The analysis will be presented in the format indicated in the table shells (Tables 2-5). We expect to complete each table for each migrant health center included in the study. Data will be collected from each site in as consistent a manner as possible, but we are aware that strict comparability between sites may not be feasible. Sites will differ in terms of the types of service coordinated, the particular arrangements negotiated for financing the coordinated service, and their accounting practices. For example, it is likely that coordinated services which are client-specific, such as prenatal visits or individual counseling sessions, are quantified differently from services which benefit a larger and undefined group, such as outreach activities or health promotion campaigns. Differences in cost data between sites which are believed to have a material impact on the presentation of findings will be clearly noted. Since each site is intended as a 'best practices" case study, we do not anticipate comparability to be a major problem; however, documentation of differences may serve to promote comparability in the future.

Those migrant health centers which are multi-site providers will not require visits to all sites, although if there are several integrated services each operated at different sites those will be visited. Cur on-site work in the health center will be for the purpose of data gathering. We will gather data through interviews, extracting data from logs or other records, measuring staffing and other items representing "expenditures" for

the service under study, and observing the flow of patients using the integrated/coordinated service.

Contacts with outside agencies may be made by phone or through personal interviews. If the service coordinated by the migrant health center is located in another provider organization, a meeting to interview key contacts to determine how the arrangements work will be necessary. If another agency has contracted for integrated services at the migrant health center, the interview may take place by phone. The cooperative agreement contact, state primary care association, and migrant health center staff will be asked about outside contacts in addition to the specific coordinated service provider. Generally a contact with the state health department will be appropriate if WIC, other public health services, or some environmental services are being studied. If the services under study are related to welfare, Medicaid, emergency need, or food stamps, the county or local welfare office may provide the information needed.

In addition, we will want to know if there is a migrant coordinating council or its equivalent at the state and/or local level. If so, did it play any role in the integration or coordination of services? Were any other migrant-specific councils or commissions involved earlier? It may be appropriate to review the minutes of meetings of such councils when arrangements for coordination of services were discussed, or to interview (directly or by phone) representatives serving on the council.

During the visit our two-person team will split up, with each collecting information from different offices and staff members. During the evening they will meet to review and compare notes, and to identify advantageous findings and items requiring further follow-up. At the conclusion of the visit, they will offer to meet with the center's director to provide a summary of observations and to indicate any loose ends identified.

Post-Site Visit Activities

The post-site visit activities will include promptly completing any follow-up phone calls, writing the case study (10-12 pages), sending a review draft and thank you letter to the Executive Director, providing a draft copy of the site report for review and comment by the regional office, and sifting through the case study for "lessons learned" and measures of achievement which will be used in the cross-site analyses and synthesis of recommendations. Note that we will offer each site the opportunity to suggest changes to our draft reports. However, we will only be able to allow a limited time for their input, and cannot promise that we will not provide the GPO with a copy prior to receipt of such suggestions. We do not propose to offer the sites confidentiality in our reports (we will *not* identify individual staff members *or* patients). Because we will not offer confidentiality of the site identification, this point will be made clear during the earliest contacts with each selected MCH.

Task 7—Conduct Test of Protocols and Instruments

This task is tentatively scheduled for February, but completion will depend on our ability to identify one of the nine selected sites willing to be visited at that time, and our being able to provide about four weeks advance notice in order to make arrangements. Therefore, our plans are based on the assumption that this test will occur sometime in February. We plan to have three people participate in this pre-test in order to maxim.2e its value both for refining the protocol and as a learning experience for the site visit staff. We will invite the GPO to participate in this visit. If she is able to do so, this will facilitate the subsequent meeting, briefing, and refinement of the protocols.

The visit to pre-test protocols will be a three-day visit, even though we will have three instead of two people to collect information. All draft protocols will be followed during the pre-visit phase, and will be used at least initially when the team arrives on site. Some modifications may be adapted after the first day, if needed. Post-site activities will be in accordance with the draft protocols, but will be supplemented as determined necessary. It is planned that a draft case study will be prepared within one week after the site visit, even if some information is still missing. This tight schedule will permit moving on to Tasks 8 and 9 while continuing to improve and expand the written report.

Task 8-Provide Oral Briefing on Site Protocol Test

The oral briefing will be scheduled immediately folowing the site visit. This will allow time for the site visit team to review its experience in using the protocols, and for the development of recommendations for modifications to the protocols. Ms. Mountain and Dr. Wallace will conduct the briefing of BHCDA personnel. The briefing will include presentation of recommendations for refining the protocol. It is intended that the briefing will also deal with the format for the case study reports (see Exhibit 5) and the documentation used for determining the cost impact of coordination and integration of services. To the extent possible, we will also distill recommendations to BHCDA from this single site in order to test the extent to which our protocols address questions of replicability, role of federal policy, and cost.

Task SF-Refine Site Visit Protocols

Within one week after the oral briefing we will have refined the protocols and submitted these to the GPO for final approval. If the revisions result in the need for additional information from the pre-test site, calls will be made to that site in order to supplement the previous information and to permit developing a uniform database for cross-site analysis and inclusion in the monograph.

Task 10—Conduct Remaining Site Visits

As soon as the GPO's approval of the fmal protocols is received, we will move to schedule the eight remaining site visits. The two teams will each schedule four visits,

preferably with each team conducting two visits during a week in the field, then spending several weeks writing their reports before returning to the field for another two visits. The schedule will be arranged to minimize travel costs while allowing time for follow-up on missing data, writing of reports, and obtaining review and comment from migrant health centers before finalizing reports. Draft copies of each site report will be submitted to the migrant health center for review within 14 days of each visit, and submitted to the GPO within 30 days of each site visit.

Given the anticipated scheduling difficulties, we expect the first two visits to occur about a month after receipt of GPO approval of the final protocols. Because one or more of the selected sites may be a "seasonal only" or downstream site which can only be scheduled in the early summer, our plan is to allow for the last site visits to occur as late as early July. This would still provide time for conducting the final briefing and submission of the draft final report by September 1.

Coordination of all site visits will be provided by Ms. Mountain and Ms. Pindus. Each will participate in at least four of the remaining visits and take responsibilitiy for assuring that the site reports are completed on a timely basis. Additional staff for site visit participation may vary, depending upon the particulars of the sites visited. However, we anticipate a high level of continuity among the site visit team members. This continuity will facilitate cross-site comparisons and synthesis of recommendations for migrant health centers and BHCDA for inclusion in the final report.

Task 11--Prepare Draft Monograph, Final Report, and Executive Summary

A final report will be compiled to record the purpose, methods, and overall findings of this study. It will also contain recommendations directed to federal agencies, including BHCDA, for facilitating appropriate integration and coordination. An executive summary which is sufficiently complete to permit separate dissemination will be prepared to summarize the study and cover the key findings and recommendations.

A separate monograph, suitable for distribution through the National Primary Care Clearinghouse, will also be prepared. This monograph will contain the nine case studies plus an extensive analysis of the experiences of these projects. It will also contain the matrix of health centers by services developed from the 1991 NMRP directory data. Analyses and tabulations from this expanded matrix will be included to draw conclusions about the extent of integration and coordination within the Migrant Health Program. Analyses will also be conducted by category of outside program (i.e., WIC, Job Training, Migrant Education, etc.) to provide direct feedback to other agencies regarding their integration and coordination with migrant health centers.

The contents of the monograph will include each of the following components as required in the RFP:

- A detailed analysis of each of the 9 case studies, including the original test site (revised and adjusted through information added after revision to the data collection and interview tools).

- The tabulation of the matrix of migrant health centers and services in which coordination and integration exist. Notation will be made of the extent of integration, with values placed on the degree of achievement (using 'self scores" provided by migrant health center and scores provided by regional offices and other relevant organizations or agencies such as primary care associations, state and local health departments, etc.); we can use the case study sites as a control group to interpret self-scored degrees of achievement.

- An analysis of the case studies will be performed to compare the integration and coordination efforts on a model-by-model basis. Careful notation will be included to indicate the operational model of the health center (i.e., delivery model, comprehensiveness, size, age, number of FTE physicians, etc.) and take a number of variables into consideration.

- The factors which create barriers to successful coordination will also be analyzed, and a prototype or generic model of those characteristics will be developed. For this analysis we will include lessons from the literature review and either confirm their applicability to migrant health centers or explain why they do not seem important.

- Likewise, the combination of factors which result in greatest success will be identified, and a diagram depicting those factors will accompany the findings. The relationship of the observed factors from our case studies and the expanded matrix analysis will be compared with those factors identified in the literature, and any differences explained.

- We will synthesize recommendations for each of the following categories:

    - Recommendations for federal intervention, including needed inter-agency arrangements or agreements, monitoring or accountability measures, incentives, and enforcement needs.

    - Barriers to avoid at the migrant health center and "other program" level, including state programs. This set of recommendations will be derived from the lessons learned on site and the recommendations to other health centers collected in the interviews.

    - Program-specific recommendations (e.g., to improve coordination with Migrant Education outreach, the following should be done . ..) will be organized for each level of intervention (federal, state, local, migrant health center), even though this is somewhat repetitive of the audience-specific recommendations above.

- Other recommendations not classifiable above. We think it particularly useful to include analyses and any resulting conclusions and recommendations which specifically address coordination and integration between state and local health departments and migrant health centers.

Task 12-Meet With GPO to Discuss Draft Reports

Within two weeks after submission of the draft final report, monograph and executive summary, the senior staff of the study team will meet with the GPO to review these documents and plan an oral briefing for HRSA officials. The meeting will identify those findings and recommendations to be highlighted in the final briefing, specify additional analyses and justifications necessary, and provide the basis for outlining the final briefing contents and time distribution. If feasible, a rehearsal of the briefing may be provided as part of this meeting.

After the meeting and before the scheduled briefing (Task 13), we will provide any updated analyses, changes in findings, and refined recommendations to the GPO During this period we will work to incorporate the GPO's comments into the study products.

Task 13-Deliver Final Briefing

The final briefing will be a professionally-organized briefing with graphs and handouts used to enhance communications. We see the agenda for the briefing as approximately the following:

- Background and purpose of the study, and why it was deemed important to perform (4 minutes)
- Outline of the methodology, including the analyses performed (6 minutes)
- Summary of the findings (10 minutes)
- Recommendations, including justifications for each (10 minutes)
- Questions and discussion (interactive with the audience) (20 minutes)

Task 14—Deliver Final Reports

Based on feedback from the GPO and the questions raised at the briefing, the final report, monograph, and executive summary will be revised. There will probably be some need to clarify points, and perhaps to add other analyses to support conclusions or recommendations. In other cases it may be useful to rephrase recommendations to be consistent with current initiatives.

Within 5 weeks after the briefing, or by September 30, the revisions will be completed and final versions prepared. The final reports, monographs, executive summary, NTIS abstract, and DHHS Evaluation Study Description Sheet will be delivered in 20 copies, including one camera-ready copy, and on floppy disk in either Word Perfect or ASCII format.